



Facility Name & ID Number Mt Vernon Health Care Center

# 0047928 Report Period Beginning: 03/01/06 Ending: 12/31/06

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	32,436	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	32,436	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	3,700	19,481		23,181
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	3,700	19,481		23,181

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.47%

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

0 (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

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 3/01/2006

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

YES  Date 3/01/2006 NO

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

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Mt Vernon Health Care Center # 0047928 Report Period Beginning: 03/01/06 Ending: 12/31/06

**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
	<b>A. General Services</b>										
1	Dietary	86,959	6,334	1,522	94,815		94,815	1,649	96,464		1
2	Food Purchase		90,490		90,490		90,490	(5,287)	85,203		2
3	Housekeeping	86,306	11,439		97,745		97,745	73	97,818		3
4	Laundry	3,458	7,153		10,611		10,611		10,611		4
5	Heat and Other Utilities			60,989	60,989		60,989	306	61,295		5
6	Maintenance	25,460	21,528	3,368	50,356		50,356	4,192	54,548		6
7	Other (specify):* <b>Home Office Benefits</b>							661	661		7
8	<b>TOTAL General Services</b>	202,183	136,944	65,879	405,006		405,006	1,594	406,600		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	742,891	41,878	3,810	788,579		788,579	5,960	794,539		10
10a	Therapy		1,564	1,680	3,244		3,244	547	3,791		10a
11	Activities	34,886	574	5,404	40,864		40,864		40,864		11
12	Social Services	20,042			20,042		20,042		20,042		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Home Office Benefits</b>							1,842	1,842		15
16	<b>TOTAL Health Care and Programs</b>	797,819	44,016	18,394	860,229		860,229	8,349	868,578		16
	<b>C. General Administration</b>										
17	Administrative	82,442		90,000	172,442		172,442	(73,753)	98,689		17
18	Directors Fees										18
19	Professional Services			3,642	3,642		3,642	6,601	10,243		19
20	Dues, Fees, Subscriptions & Promotions			5,117	5,117		5,117	697	5,814		20
21	Clerical & General Office Expenses	2,572	4,414	6,376	13,362		13,362	25,206	38,568		21
22	Employee Benefits & Payroll Taxes			149,536	149,536		149,536	2,783	152,319		22
23	Inservice Training & Education			212	212		212	212	424		23
24	Travel and Seminar							239	239		24
25	Other Admin. Staff Transportation			2,868	2,868		2,868	1,687	4,555		25
26	Insurance-Prop.Liab.Malpractice			25,799	25,799		25,799	1,248	27,047		26
27	Other (specify):* <b>Home Office Benefits</b>							4,628	4,628		27
28	<b>TOTAL General Administration</b>	85,014	4,414	283,550	372,978		372,978	(30,452)	342,526		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,085,016	185,374	367,823	1,638,213		1,638,213	(20,509)	1,617,704		29

SEE ACCOUNTANTS' COMPILATION REPORT

\*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.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Mt Vernon Health Care Center

#0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			49,644	49,644		49,644	(2,253)	47,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,589	44,589		44,589	18,439	63,028			32
33	Real Estate Taxes			30,000	30,000		30,000	757	30,757			33
34	Rent-Facility & Grounds			25,249	25,249		25,249	734	25,983			34
35	Rent-Equipment & Vehicles			12,237	12,237		12,237	384	12,621			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			161,719	161,719		161,719	18,061	179,780			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			53,583	53,583		53,583		53,583			42
43	Other (specify):* <b>Nonallowable Cost</b>	18,101		10,403	28,504		28,504	(28,504)				43
44	<b>TOTAL Special Cost Centers</b>	18,101		63,986	82,087		82,087	(28,504)	53,583			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,103,117	185,374	593,528	1,882,019		1,882,019	(30,952)	1,851,067			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

**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	(1,665)	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	(8,710)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(285)	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	(3,250)	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				24
25	Fund Raising, Advertising and Promotional	(2,387)	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 <u>See Pg 5A</u>	(38,509)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (54,806)		\$	30

**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)	23,854	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 23,854		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (30,952)		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		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Mt Vernon Health Care Center

ID# 0047928

Report Period Beginning: 03/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (2,616)	43	1
2	Labs - Part A	(160)	43	2
3	Marketing Salaries	(18,101)	43	3
4	Marketing Supplies	(40)	43	4
5	Offset Meal Income	(2,585)	2	5
6	Misc Income - Other	(984)	21	6
7	Offset home office travel	(6,102)	24	7
8	Offset home office architect fees	(514)	19	8
9	Disallowed interest expense	(7,407)	32	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(38,509)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mt Vernon Health Care Center# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,649	0	0	0	0	0	0	0	0	0	1,649	1
2	Food Purchase	(2,585)	81	0	0	0	0	0	0	0	0	0	(2,504)	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	306	0	0	0	0	0	0	0	0	0	306	5
6	Maintenance	0	4,192	0	0	0	0	0	0	0	0	0	4,192	6
7	Other (specify):*	0	661	0	0	0	0	0	0	0	0	0	661	7
8	<b>TOTAL General Services</b>	<b>(2,585)</b>	<b>6,962</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,377</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,960	0	0	0	0	0	0	0	0	0	5,960	10
10a	Therapy	0	547	0	0	0	0	0	0	0	0	0	547	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,842	0	0	0	0	0	0	0	0	0	1,842	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>8,349</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,349</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(73,753)	0	0	0	0	0	0	0	0	0	(73,753)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(514)	7,115	0	0	0	0	0	0	0	0	0	6,601	19
20	Fees, Subscriptions & Promotions	0	697	0	0	0	0	0	0	0	0	0	697	20
21	Clerical & General Office Expenses	(984)	0	26,190	0	0	0	0	0	0	0	0	25,206	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	212	0	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	(6,102)	0	6,341	0	0	0	0	0	0	0	0	239	24
25	Other Admin. Staff Transportation	0	0	1,687	0	0	0	0	0	0	0	0	1,687	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,248	0	0	0	0	0	0	0	0	1,248	26
27	Other (specify):*	0	0	4,628	0	0	0	0	0	0	0	0	4,628	27
28	<b>TOTAL General Administration</b>	<b>(7,600)</b>	<b>(65,941)</b>	<b>40,306</b>	<b>0</b>	<b>(33,235)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(10,185)</b>	<b>(50,630)</b>	<b>40,306</b>	<b>0</b>	<b>(20,509)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mt Vernon Health Care Center# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(8,710)	0	6,457	0	0	0	0	0	0	0	0	(2,253)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,407)	0	25,846	0	0	0	0	0	0	0	0	18,439	32
33	Real Estate Taxes	0	0	757	0	0	0	0	0	0	0	0	757	33
34	Rent-Facility & Grounds	0	0	734	0	0	0	0	0	0	0	0	734	34
35	Rent-Equipment & Vehicles	0	0	384	0	0	0	0	0	0	0	0	384	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(16,117)</b>	<b>0</b>	<b>34,178</b>	<b>0</b>	<b>18,061</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(28,504)	0	0	0	0	0	0	0	0	0	0	(28,504)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(28,504)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(28,504)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(54,806)</b>	<b>(50,630)</b>	<b>74,484</b>	<b>0</b>	<b>(30,952)</b>	<b>45</b>							

Facility Name & ID Number

Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

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
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,649	\$ 1,649	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	81	81	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	73	73	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	306	306	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,192	4,192	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	661	661	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,960	5,960	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	547	547	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,842	1,842	10
11	V	17 Administrative	90,000	Petersen Health Care, Inc.	100.00%	16,247	(73,753)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,115	7,115	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	697	697	13
14	Total		\$ 90,000			\$ 39,370	\$ * (50,630)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 26,190	\$	26,190	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	212		212	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	6,341		6,341	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,687		1,687	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,248		1,248	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,628		4,628	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,457		6,457	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,587		3,587	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	22,259		22,259	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	757		757	24
25	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	734		734	25
26	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	384		384	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	<b>Total</b>		\$			\$ 74,484	\$ *	74,484	39

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

Facility Name & ID Number Mt Vernon Health Care Center # 0047928 Report Period Beginning: 03/01/06 Ending: 12/31/06

## 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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.22	2.44	Salary	\$ 16,247	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,247		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 Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	23,181	\$ 1,649	1
2	2	Food	Patient Days	1,141,463	56	3,989		23,181	81	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		23,181	73	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		23,181	306	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	23,181	4,192	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		23,181	661	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	23,181	5,960	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		23,181	547	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		23,181	1,842	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	23,181	16,247	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361		23,181	7,115	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		23,181	697	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	23,181	26,190	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		23,181	212	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		23,181	6,341	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		23,181	1,687	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		23,181	1,248	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		23,181	4,628	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		23,181	6,457	20
21	32	Interest	Patient Days	1,141,463	56	176,614		23,181	3,587	21
22	32	Interest	Patient Days	316,605	56	304,014		23,181	22,259	22
23	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		23,181	757	23
24	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		23,181	734	24
25	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		23,181	384	25
26	TOTALS					\$ 4,814,249	\$ 2,234,999		\$ 113,854	26

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	US Bank		X	Mortgage	Varies	12/09/04	\$ 3,660,000	\$ 889,482	11/09/11	0.0699	\$ 37,037	1						
2												2						
3							Allocation from Home Office				25,846	3						
4							Bond Amortization				145	4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 3,660,000	\$ 889,482			\$ 63,028	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,660,000	\$ 889,482			\$ 63,028	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	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.)	2005	\$	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	3	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,000	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>Home Office allocation</b>			757	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	30,757	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	8		
	2002	9		
	2003	10		
	2004	11		
	2005	12		
<b>Previous provider was a not for profit organization and not required to pay 2005 taxes due in 2006.</b>				
<b>Real estate taxes accrued based on best estimate by provider.</b>				
<b>FOR BHF USE ONLY</b>				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Mt Vernon Health Care Center COUNTY JEFFERSON

FACILITY IDPH LICENSE NUMBER 0047928

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-36-126-015</u>	<u>Nursing Home</u>	\$ <u>          </u>	\$ <u>0</u>
2. <u>07-30-401-007</u>	<u>Nursing Home</u>	\$ <u>          </u>	\$ <u>0</u>
3. <u>07-30-401-013</u>	<u>Nursing Home</u>	\$ <u>          </u>	\$ <u>0</u>
4. <u>07-30-404-011</u>	<u>Nursing Home</u>	\$ <u>          </u>	\$ <u>0</u>
5. <u>                  </u>	<u>Home Office allocation</u>	\$ <u>          </u>	\$ <u>757.00</u>
6. <u>                  </u>	<u>                  </u>	\$ <u>          </u>	\$ <u>          </u>
7. <u>                  </u>	<u>                  </u>	\$ <u>          </u>	\$ <u>          </u>
8. <u>                  </u>	<u>                  </u>	\$ <u>          </u>	\$ <u>          </u>
9. <u>                  </u>	<u>                  </u>	\$ <u>          </u>	\$ <u>          </u>
10. <u>                  </u>	<u>                  </u>	\$ <u>          </u>	\$ <u>          </u>
<b>TOTALS</b>		\$ <u>          </u>	\$ <u>757.00</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories One

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>120,000</u>	<u>2005</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>120,000</b>		<b>\$ 60,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	106	2005	1970	\$ 1,190,500	\$ 29,763	25	\$ 24,142	\$ (5,621)	\$ 23,810
5									
6	Allocated								
7	from Home	2006		16,590			605	605	605
8	Office								
<b>Improvement Type**</b>									
9	Original Land improvements		2006	15,000		15	500	500	1,249
10	Durolast		2006	26,843		20	671	671	
11	Sign front door		2006	3,118		20	78	78	
12									
13									
14									
15									
16									
17									
18	Land improvement booked				583			(583)	
19	Building booked				29,763			(29,763)	
20	Building improvement booked				403			(403)	
21	Equipment booked				18,563			(18,563)	
22									
23	2006 Home Office allocation - leasehold improvements			27			2	2	2
24	2006 Home Office allocation - land & land improvements			959			74	74	74
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,253,037		79,075	26,072	(53,003)	25,740

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

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	\$ 214,500	\$ 18,563	\$ 15,368	\$ (3,195)	7-10	\$ 15,452	71
72	Current Year Purchases	1,736		174	174	5	174	72
73	Fully Depreciated Assets							73
74	Allocated from home office			5,777	5,777			74
75	TOTALS	\$ 216,236	\$ 18,563	\$ 21,319	\$ 2,756		\$ 15,626	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	N/A			\$	\$	\$	\$		\$	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)	\$ 1,529,273	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,638	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,391	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (50,247)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 41,366	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: TI - Mt. Vernon, LLC

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:	<u>1970</u>	<u>106</u>	<u>2006</u>	\$ <u>25,249</u>	<u>1</u>	<u>None</u>	3
4	Additions							4
5	Other: <u>Home Office allocation</u>				<u>734</u>			5
6								6
7	TOTAL		<u>106</u>		\$ <u>25,983</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 12,621 Description: Copier-3900, Dishwasher-590, Nursing Equip-5635, Laundry Equip-2112, Home Office-384

(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>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning N/A

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2007 \$ \_\_\_\_\_

13. /2008 \$ \_\_\_\_\_

14. /2009 \$ \_\_\_\_\_

\* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	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	10A(2),(3)	hrs		22	1,680	1,564	22	3,244	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	22	\$ 1,680	\$ 1,564	22	\$ 3,244	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Mt Vernon Health Care Center

# 0047928

Report Period Beginning: 03/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u> )	358,175	358,175	3
4	Supply Inventory (priced at <u>          </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,940	7,940	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>                          </u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 366,115	\$ 366,115	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000	60,000	13
14	Buildings, at Historical Cost	1,217,343	1,253,037	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	219,354	216,236	16
17	Accumulated Depreciation (book methods)	(49,395)	(41,366)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Investment in subs</u> )	1,400	1,400	22
23	Other(specify): <u>                          </u>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,463,702	\$ 1,489,307	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,829,817	\$ 1,855,422	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 607,182	\$ 607,182	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,610	85,610	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,488	4,488	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable	6,242	6,242	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued expenses</u>	22,675	22,675	36
37	<u>Due to owners</u>	90,652	90,652	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 846,849	\$ 846,849	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	889,482	889,482	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>  </u>			43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 889,482	\$ 889,482	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,736,331	\$ 1,736,331	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 93,486	\$ 119,091	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,829,817	\$ 1,855,422	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>84,303</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>84,303</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>9,180</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>rounding</b>	<b>3</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>9,183</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>93,486</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,887,630	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,887,630	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
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	2,585	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,585	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous revenue</u>	984	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 984	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,891,199	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	405,006	31
32	Health Care	860,229	32
33	General Administration	372,978	33
	<b>B. Capital Expense</b>		
34	Ownership	161,719	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	28,504	35
36	Provider Participation Fee	53,583	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,882,019	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	9,180	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 9,180	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity is a cash basis taxpayer.

\*\*\* 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 Mt Vernon Health Care Center

# 0047928

Report Period Beginning:

03/01/06

Ending:

12/31/06

**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	1,733	1,733	\$ 36,393	\$ 21.00	1
2	Assistant Director of Nursing	1,685	1,685	12,936	7.68	2
3	Registered Nurses	1,173	1,193	20,990	17.60	3
4	Licensed Practical Nurses	14,635	14,818	261,272	17.63	4
5	CNAs & Orderlies	41,248	42,031	377,892	8.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,476	1,476	16,665	11.29	9
10	Activity Assistants	1,664	1,664	18,221	10.95	10
11	Social Service Workers	2,320	1,934	20,042	10.37	11
12	Dietician					12
13	Food Service Supervisor	1,733	1,733	19,879	11.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,540	9,655	67,080	6.95	15
16	Dishwashers					16
17	Maintenance Workers	3,045	3,111	25,460	8.18	17
18	Housekeepers	11,615	11,752	86,306	7.34	18
19	Laundry	391	391	3,458	8.85	19
20	Administrator	1,733	1,733	45,899	26.48	20
21	Assistant Administrator	3,039	3,051	36,543	11.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	214	214	2,572	12.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	98	116	1,097	9.46	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	1,985	1,985	32,311	16.28	32
33	Other(specify) <u>Marketing</u>	1,294	1,294	18,101	13.99	33
34	TOTAL (lines 1 - 33)	100,622	101,570	\$ 1,103,117 *	\$ 10.86	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	46	\$ 1,522	1,3	35
36	Medical Director	Monthly	7,500	9,3	36
37	Medical Records Consultant	2 visits	153	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,361	10,3	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)	46	\$ 12,536		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6	\$ 296	10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6	\$ 296		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Carrell Breeze	Administrator	0	\$ 48,158	Workers' Compensation Insurance	\$ 25,328	IDPH License Fee	\$ 421		
Debbie Jackson	Asst. Administrator	0	34,284	Unemployment Compensation Insurance	32,532	Advertising: Employee Recruitment	1,777		
				FICA Taxes	77,758	Health Care Worker Background Check (Indicate # of checks performed <u>275</u> )	2,750		
				Employee Health Insurance	9,360	Patient Background Checks			
				Employee Meals	2,783	Misc Dues & Subscriptions	169		
				Illinois Municipal Retirement Fund (IMRF)*		Allocated from home office	697		
				Employee Relations	4,558	Less: Public Relations Expense	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,442			Non-allowable advertising	( )		
B. Administrative - Other						Yellow page advertising	( )		
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
Management Fees (eliminated in column 7)			\$ 90,000		\$ 152,319		\$ 5,814		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 90,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Emdeon	Computer Services		\$ 352	N/A			Out-of-State Travel	\$	
LTC Solutions, Inc.	Computer Services		3,290				In-State Travel		
							Seminar Expense		
							Allocated from home office	239	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,642	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 239

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Mt Vernon Health Care Center

# 0047928

Report Period Beginning: 03/01/06

Ending: 12/31/06

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,590 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 during this cost report period. \$ 53,583  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 2,783 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,377
- (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? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (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