

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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><b>I. IDPH License ID Number:</b> <u>0035998</u></p> <p><b>Facility Name:</b> <u>Mount Vernon Countryside Manor</u></p> <p><b>Address:</b> <u>606 East IL Hwy 15, New Fairfield Road</u> <u>Mount Vernon</u> <u>62864</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Jefferson</u></p> <p><b>Telephone Number:</b> <u>(618) 242-1800</u> <b>Fax #</b> <u>(618) 242-1878</u></p> <p><b>HFS ID Number:</b> <u>37-1239928-1</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>5/9/1990</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Cindy A. Tefeller</u> <b>Telephone Number:</b> <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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>COMPILATION REPORT ATTACHED</u> (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>Cindy A. Tefeller Partner</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) <u>C.J. Schlosser &amp; Company, L.L.C. 233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>COMPILATION REPORT ATTACHED</u> (Date) _____		(Print Name and Title) <u>Cindy A. Tefeller Partner</u>		(Firm Name & Address) <u>C.J. 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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor

# 0035998 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)		0	2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	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		5 Total
		8	SNF	2,305		1,257
9	SNF/PED					9
10	ICF	17,736	6,260		23,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,041	7,517	6,151	33,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

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

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 32 and days of care provided 6,151

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	159,736	9,160	7,741	176,637		176,637		176,637		1
2	Food Purchase		139,562		139,562		139,562	(3,970)	135,592		2
3	Housekeeping	132,413	17,960		150,373		150,373	755	151,128		3
4	Laundry	49,348	26,237		75,585		75,585		75,585		4
5	Heat and Other Utilities			101,248	101,248		101,248	1,104	102,352		5
6	Maintenance	39,568	100,979	1,020	141,567		141,567	45,728	187,295		6
7	Other (specify):* <b>Sanitation</b>			7,180	7,180		7,180		7,180		7
8	<b>TOTAL General Services</b>	<b>381,065</b>	<b>293,898</b>	<b>117,189</b>	<b>792,152</b>		<b>792,152</b>	<b>43,617</b>	<b>835,769</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,554,889	102,988	3,164	1,661,041	3,852	1,664,893		1,664,893		10
10a	Therapy			849,679	849,679		849,679		849,679		10a
11	Activities	54,064	2,985	2,689	59,738		59,738		59,738		11
12	Social Services	58,498			58,498		58,498		58,498		12
13	CNA Training										13
14	Program Transportation		10,566		10,566		10,566		10,566		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,667,451</b>	<b>116,539</b>	<b>861,532</b>	<b>2,645,522</b>	<b>3,852</b>	<b>2,649,374</b>		<b>2,649,374</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	64,559	26,334	285,000	375,893	(11,958)	363,935	(143,261)	220,674		17
18	Directors Fees										18
19	Professional Services			11,928	11,928		11,928	4,050	15,978		19
20	Dues, Fees, Subscriptions & Promotions			14,826	14,826	3,106	17,932	(10,701)	7,231		20
21	Clerical & General Office Expenses	22,954	18,283	24,941	66,178		66,178	39,602	105,780		21
22	Employee Benefits & Payroll Taxes			368,291	368,291		368,291	17,860	386,151		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,395	1,395		1,395	761	2,156		24
25	Other Admin. Staff Transportation							3,719	3,719		25
26	Insurance-Prop.Liab.Malpractice			52,533	52,533	5,000	57,533	2,432	59,965		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>87,513</b>	<b>44,617</b>	<b>758,914</b>	<b>891,044</b>	<b>(3,852)</b>	<b>887,192</b>	<b>(85,538)</b>	<b>801,654</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,136,029</b>	<b>455,054</b>	<b>1,737,635</b>	<b>4,328,718</b>		<b>4,328,718</b>	<b>(41,921)</b>	<b>4,286,797</b>		<b>29</b>

\*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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			175,331	175,331		175,331	10,838	186,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			80,875	80,875		80,875	956	81,831			33
34	Rent-Facility & Grounds			6,000	6,000		6,000	(6,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			262,206	262,206		262,206	5,794	268,000			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		255,067	45,526	300,593		300,593		300,593			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298		55,298		55,298			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		255,067	100,824	355,891		355,891		355,891			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,136,029	710,121	2,100,665	4,946,815		4,946,815	(36,127)	4,910,688			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

**VI. ADJUSTMENT DETAIL**  
 A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,294)	2		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	(281)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,395)	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	(6,144)	17		19
20	Contributions	(1,000)	20		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	(5,008)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,635)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,976)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (32,733)		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,394)	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (3,394)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (36,127)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Countryside Manor

ID# 0035998

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Adjust for depr on items req'd to be capitalized	\$ 331	30	1
2	Eliminate 2008 IHCA dues	(4,191)	20	2
3	Offset voided checks	(1,070)	17	3
4	Offset telephone refund	(100)	21	4
5	Eliminate lobbying portion of IHCA dues	(946)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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>	(5,976)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,970)	0	0	0	0	0	0	0	0	0	0	(3,970)	2
3	Housekeeping	0	755	0	0	0	0	0	0	0	0	0	755	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,104	0	0	0	0	0	0	0	0	0	1,104	5
6	Maintenance	0	45,728	0	0	0	0	0	0	0	0	0	45,728	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,970)</b>	<b>47,587</b>	<b>0</b>	<b>43,617</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	0	0	0	0	0	0	0	0	0	0	0	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(7,214)	(136,047)	0	0	0	0	0	0	0	0	0	(143,261)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,050	0	0	0	0	0	0	0	0	0	4,050	19
20	Fees, Subscriptions & Promotions	(11,145)	444	0	0	0	0	0	0	0	0	0	(10,701)	20
21	Clerical & General Office Expenses	(10,735)	50,337	0	0	0	0	0	0	0	0	0	39,602	21
22	Employee Benefits & Payroll Taxes	0	17,860	0	0	0	0	0	0	0	0	0	17,860	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	761	0	0	0	0	0	0	0	0	0	761	24
25	Other Admin. Staff Transportation	0	3,719	0	0	0	0	0	0	0	0	0	3,719	25
26	Insurance-Prop.Liab.Malpractice	0	2,432	0	0	0	0	0	0	0	0	0	2,432	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(29,094)</b>	<b>(56,444)</b>	<b>0</b>	<b>(85,538)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(33,064)</b>	<b>(8,857)</b>	<b>0</b>	<b>(41,921)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998

Report Period Beginning:

01/01/2007 Ending:12/31/2007

## 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)
	<b>D. Ownership</b>												
30	Depreciation	331	10,507	0	0	0	0	0	0	0	0	0	10,838 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	956	0	0	0	0	0	0	0	0	0	956 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	<b>TOTAL Ownership</b>	<b>331</b>	<b>11,463</b>	<b>(6,000)</b>	<b>0</b>	<b>5,794 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(32,733)</b>	<b>2,606</b>	<b>(6,000)</b>	<b>0</b>	<b>(36,127) 45</b>							

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 Countryside Manor, Inc.	Aviston	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Taylorville Care Center, Inc.	Taylorville			
Jerry & Marilyn King	100.00	Golden Manor Nursing Home, Inc.	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%	\$ 755	\$ 755 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	1,104	1,104 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	45,728	45,728 3
4	V	17 See Schedule VIII	285,000	King Management Co.	100.00%	148,953	(136,047) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	4,050	4,050 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	444	444 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	50,337	50,337 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	17,860	17,860 8
9	V	24 See Schedule VIII		King Management Co.	100.00%	761	761 9
10	V	25 See Schedule VIII		King Management Co.	100.00%	3,719	3,719 10
11	V	26 See Schedule VIII		King Management Co.	100.00%	2,432	2,432 11
12	V	30 See Schedule VIII		King Management Co.	100.00%	10,507	10,507 12
13	V	33 See Schedule VIII		King Management Co.	100.00%	956	956 13
14	Total		\$ 285,000			\$ 287,606	\$ * 2,606 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Land Lease	\$ 6,000	Jerry King		\$	\$ (6,000)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,000			\$ 0	\$ * (6,000)	39

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

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	92,896	16	31.70	Salary	\$ 43,121	17,8	1
2	Denise King	Regional Director	Administrative	0.00	217,875	19	31.70	Salary	101,134	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	59,610	16	31.70	Salary	27,670	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	211,681	0	0.00	Salary	0	N/A	4
5	Marilyn King	Owner	Mgmt/Consultant	100.00	2,732	1	31.70	Salary	1,268	17,8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 173,193		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: 01/01/2007 Ending: 2/31/2007

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, IL 62263  
 Phone Number (618) 327-3064  
 Fax Number (618) 327-3083

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	3	Housekeeping	106,310	4	\$ 2,381	\$	33,703	\$ 755	1
2	5	Utilities	106,310	4	3,483		33,703	1,104	2
3	6	Maintenance	106,310	4	144,242	87,280	33,703	45,728	3
4	17	Administrative	106,310	4	469,846	459,027	33,703	148,953	4
5	19	Professional Fees	106,310	4	12,776		33,703	4,050	5
6	20	Dues, Fees, & Subscriptions	106,310	4	1,399		33,703	444	6
7	21	Clerical and Office Expense	106,310	4	158,780	139,605	33,703	50,337	7
8	22	Employee Benefits	106,310	4	56,336		33,703	17,860	8
9	24	Travel & Seminars	106,310	4	2,399		33,703	761	9
10	25	Other Administrative Transp.	106,310	4	11,730		33,703	3,719	10
11	26	Insurance	106,310	4	7,671		33,703	2,432	11
12	30	Depreciation - Other	106,310	4	14,162		33,703	4,490	12
13	30	Depreciation - Vehicles	106,310	4	18,979		33,703	6,017	13
14	33	Real Estate Taxes	106,310	4	3,014		33,703	956	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 907,198	\$ 685,912		\$ 287,606	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Schedule Not Applicable						\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	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>						\$	\$			\$	15

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

\* 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**

		<b>Important</b> , 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 2006 report.		\$ <b>106,000</b>	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.)		\$ <b>91,875</b>	2	
3.	Under or (over) accrual (line 2 minus line 1).		\$ <b>(14,125)</b>	3	
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>95,000</b>	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>TOTAL REFUND \$ _____ For _____ Tax Year. (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.		\$ <b>80,875</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	83,678	8	
		2003	102,884	9	
		2004	101,790	10	
		2005	104,165	11	
		2006	91,875	12	
<b>Line 4: Accrual is based on 2006 taxes paid</b>		<b>Line 7: Real Estate Tax Expense \$80,875</b>			
		Home Office allocation 956			
		Total Real Estate Tax \$81,831			
13.	FROM R. E. TAX STATEMENT FOR 2006	\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 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 Cos**

Enter the tax index number and real estate tax assessed for 2006 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 2006

(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>07-28-376-013</u>	<u>56-2-784-02</u>	\$ <u>143,368.00</u>	\$ <u>91,875.00</u>
2. _____	<u>LMC Plaza - Lots 1 thru 5</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>143,368.00</u>	\$ <u>91,875.00</u>

**B. Real Estate Tax Cost Allocation:**

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  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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

**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 &amp; ID Number Mount Vernon Countryside Manor

# 0035998 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1C. 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 ground (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)

Residential Living Center is a 50 unit, 36,000 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 95,254	1
2	Home Office		1989 & 1995	1,994	2
3	TOTALS			\$ 97,248	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	101	1990	1990	\$ 2,725,128	\$ 90,837	30	\$ 90,837		\$ 1,604,683	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Landscaping		1990	26,544		10			26,544	9
10	Parking Lot		1990	26,563		10			26,563	10
11	Door & Screen		1992	1,700		10			1,700	11
12	Vanity & Medicine Cabinet		1992	1,136		10			1,136	12
13	Garage		1993	7,238	483	15	483		6,957	13
14	Water Heater		1995	2,960	197	15	197		2,499	14
15	Smoke Detectors		1996	812		10			812	15
16	Air Conditioners - 2		1996	1,342		5			1,342	16
17	Multiflow Furnace/Condensing Unit		1996	1,541		5			1,541	17
18	Storage Building Roof		1996	5,100		10			5,100	18
19	Asphalt East Parking Lot		1996	2,373		10			2,373	19
20	Air Conditioners - 2		1996	1,549		5			1,549	20
21	Entry Control System		1996	1,133		10			1,133	21
22	Vinyl Floor Covering		1996	4,465		10			4,465	22
23	Fire Alarm System		1997	13,564	904	15	904		9,721	23
24	Furnace & Tempering Valve		1997	2,112	141	15	141		1,525	24
25	Air Conditioners - 2		1997	1,502	75	10	75		1,502	25
26	Water Heater		1998	3,273	218	15	218		2,182	26
27	Air Freshener System		1998	1,314	131	10	131		1,303	27
28	Air Freshener System		1998	1,300	130	10	130		1,224	28
29	Gazebo		1998	2,974	198	15	198		1,883	29
30	Water Heater		1999	3,414	227	15	227		1,953	30
31	Water Heater		1999	2,429	162	15	162		1,390	31
32	Carpet		2000	9,666	966	10	966		6,927	32
33	Flooring		2000	18,661	1,866	10	1,866		13,218	33
34	Concrete Pad for Gazebo		2000	4,303		15		288	2,177	34
35	Landscaping		2001	7,305	731	10	731		4,748	35
36	Electrical Repairs		2001	6,691	669	10	669		4,572	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 &amp; ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	\$	\$ 1,281		37
38	Cabinets	2001	28,181	1,409	20	1,409		9,628		38
39	Office Remodel	2002	5,319	354	15	354		1,921		39
40	Wall Brackets	2002	4,577	457	10	457		2,632		40
41	Shower Room Tile	2002	3,108	310	10	310		1,606		41
42	Air Conditioners - 8	2002	6,164	1,233	5	1,233		6,164		42
43	Air Conditioners - 7	2003	5,220	1,044	5	1,044		5,046		43
44	Telephone System	2003	9,538	954	10	954		4,133		44
45	Air Conditioners - 5	2003	4,683	937	5	937		4,606		45
46	Water Softner System	2003	6,199	517	12	517		2,540		46
47	HVAC Units - 9	2004	6,493	1,299	5	1,299		5,194		47
48	HVAC Units - 3	2004	2,164	433	5	433		1,695		48
49	HVAC Units - 10	2004	7,214	1,443	5	1,443		5,651		49
50	Wallcovering	2004	10,456	2,091	5	2,091		7,145		50
51	Doors & Kickplates	2004	5,262	351	15	351		1,316		51
52	Concrete Driveway	2004	4,257	284	15	284		946		52
53	Landscaping	2005	20,005	2,001	10	2,001		4,334		53
54	Lighting -300 Hall Exit	2005	3,269	327	10	327		844		54
55	3 HVAC Units	2005	2,417	483	5	483		1,088		55
56	Sprinkler Pipe Replacement	2006	36,670	1,467	25	1,467		2,200		56
57	Parking Lot Slab	2006	22,000	1,467	15	1,467		1,956		57
58	Window Treatments	2006	16,296	1,630	10	1,630		1,901		58
59	Painting & Wallpapering	2006	29,844	5,969	5	5,969		6,964		59
60	Flooring	2006	62,193	6,219	10	6,219		7,256		60
61	7 Heating & Cooling Units	2006	3,731	373	10	373		497		61
62	Water Heater	2006	5,525	553	10	553		967		62
63	Water Heater	2006	5,153	515	10	515		987		63
64	Wall Guards	2006	3,478	696	5	696		754		64
65	Light Fixtures	2006	1,278	128	10	128		149		65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,211,531	\$ 133,062		\$ 133,350	\$ 288	\$ 1,834,123		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12A, Carried Forward		\$ 3,211,531	\$ 133,062		\$ 133,350	\$ 288	\$ 1,834,123	1
2									2
3	Wall Guard	2007	2,191	201	10	201		201	3
4	Nurse Station Flooring	2007	10,127	844	10	844		844	4
5	Custom Nurse Station	2007	17,030	1,183	12	1,183		1,183	5
6	Custom Cabinetry and Tops	2007	11,369	790	12	790		790	6
7	New Roof	2007	90,380	6,779	10	6,779		6,779	7
8	Blinds	2007	2,019	303	5	303		303	8
9	Gutters	2007	6,500	433	10	433		433	9
10	Commercial Heater	2007	5,846	487	10	487		487	10
11									11
12									12
13	Home Office Parking Lot	1989	627		5			627	13
14	Home Office New Building	1995	31,078		25	1,243	1,243	15,124	14
15	Home Office Interior Finishes	1996	1,928		15	128	128	1,478	15
16	Home Office Carpet	1996	674		5			674	16
17	Home Office Cabinets	1996	1,066		20	53	53	613	17
18	Home Office Electrical	1996	369		15	25	25	283	18
19	Home Office Front Door	2002	507		10	51	51	266	19
20	Home Office Wallpaper	2007	290		5	5	5	5	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	TOTAL (lines 1 thru 33)		\$ 3,393,532	\$ 144,082		\$ 145,875	\$ 1,793	\$ 1,864,213	34

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	\$ 203,995	\$ 18,858	\$ 21,808	\$ 2,950	3-10 yrs	\$ 103,811	71
72	Current Year Purchases	25,472	2,177	2,255	78	5-10 yrs	2,255	72
73	Fully Depreciated Assets	456,037					456,037	73
74								74
75	TOTALS	\$ 685,504	\$ 21,035	\$ 24,063	\$ 3,028		\$ 562,103	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	2000 Chevy LS Van w/ Lift	2001	\$ 22,659	\$ 409	\$ 409		4	\$ 21,330	76
77	Facility	2003 Ford Supreme Shuttle Bus	2003	40,750	9,338	9,338		4	40,750	77
78	Facility	Utility Trailer	2004	1,867	467	467		4	1,672	78
79	Home Office Vehicles	Various	Various	35,363		6,017	6,017	4	5,358	79
80	TOTALS			\$ 100,639	\$ 10,214	\$ 16,231	\$ 6,017		\$ 69,110	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,276,923 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,331 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,169 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,838 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,495,426 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? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

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  N/A NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$ _____	\$ _____	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.

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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>	

- (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	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 of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	10a,3	hrs	\$	15,350	\$	310,362	\$		15,350	\$	310,362	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		2,888		165,004			2,888		165,004	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	10a,3	hrs		18,792		374,313			18,792		374,313	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						255,067			255,067	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 & Ambul.	39,3					45,526					45,526	13
14	TOTAL			\$	37,030	\$	895,205	\$	255,067	37,030	\$	1,150,272	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

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 448,510	\$	1
2	Cash-Patient Deposits	1,790		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,371 )	920,185		3
4	Supply Inventory (priced at Cost )	8,886		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,453		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	20,955		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,415,779	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,349,854		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	713,513		16
17	Accumulated Depreciation (book methods)	(2,436,299)		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 (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,627,068	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,042,847	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 259,506	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,290		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,622		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,657		31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 585,075	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 585,075	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,457,772	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,042,847	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,476,747	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,476,747	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	491,025	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	(510,000)	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)	\$ (18,975)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,457,772	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning: 01/01/2007

Ending:

Page 19  
12/31/2007

**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	\$ 5,221,929	1
2	Discounts and Allowances for all Levels	(1,041,922)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,180,007	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,197,665	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,197,665	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	1,294	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	37,430	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>	\$ 38,724	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	16,907	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,907	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation	465	28
28a	Miscellaneous	4,072	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,537	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,437,840	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	792,152	31
32	Health Care	2,645,522	32
33	General Administration	891,044	33
<b>B. Capital Expense</b>			
34	Ownership	262,206	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	300,593	35
36	Provider Participation Fee	55,298	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,946,815	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	491,025	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 491,025	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.

\*\*\* 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 &amp; ID Number Mount Vernon Countryside Manor

# 0035998

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

12/31/2007

## 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	1,824	2,094	\$ 53,395	\$ 25.50	1
2	Assistant Director of Nursing	2,061	2,617	49,076	18.75	2
3	Registered Nurses	14,435	16,151	297,389	18.41	3
4	Licensed Practical Nurses	20,662	22,634	352,701	15.58	4
5	CNAs & Orderlies	77,617	80,460	780,650	9.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,679	6,142	54,064	8.80	10
11	Social Service Workers	5,206	5,453	58,498	10.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,157	17,984	159,736	8.88	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,272	39,568	17.42	17
18	Housekeepers	14,421	16,188	132,413	8.18	18
19	Laundry	6,157	6,683	49,348	7.38	19
20	Administrator	1,832	2,138	64,559	30.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,911	2,111	22,954	10.87	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	1,839	2,107	21,678	10.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,786	185,034	\$ 2,136,029 *	\$ 11.54	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	146	\$ 7,215	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	23	1,066	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,135	10,3	39
40	Physical Therapy Consultant	Contract	963	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,689	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	210	\$ 19,068		49

## C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ Section N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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		
Marla Howard	Administrator	0	\$ 64,559	Workers' Compensation Insurance	\$ 132,158	IDPH License Fee	\$		
				Unemployment Compensation Insurance	35,102	Advertising: Employee Recruitment	1,414		
				FICA Taxes	158,100	Health Care Worker Background Check (Indicate # of checks performed _____)	2,000		
				Employee Health Insurance	40,395	Patient Background Checks			
				Employee Meals		Subscriptions	300		
				Illinois Municipal Retirement Fund (IMRF)*		Franchise Taxes	325		
				Employee Relations	350	Miscellaneous Dues & Licenses	608		
				Pension Expense	2,106	Home Office Allocation	444		
				Home Office Allocation	17,860	IHCA Dues	2,140		
				Employee Physicals	80	Less: Public Relations Expense ( )			
						Non-allowable advertising ( )			
						Yellow page advertising ( )			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,559	TOTAL (agree to Schedule V, line 22, col.8)		\$ 386,151	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fee			\$ 285,000	Section N/A			Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 285,000				In-State Travel		
C. Professional Services									
Vendor/Payee	Type		Amount						
C.J. Schlosser & Co.	Accounting		\$ 9,675						
Greensfelder, Henker & Gale	Legal		2,253						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,928	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,156

\* 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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
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 Mount Vernon Countryside Manor

# 0035998

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA Dues \$2,140
- (3) Did the nursing home make political contributions or payments to a political 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? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 139 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. \$ 55,298  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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 benefit: on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,294
- (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? 74%
- 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 \$5,000, 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  
12/31/2007

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
NURSING AND MEDICAL RECORDS	10	3,852
FEES & SUBSCRIPTIONS	20	3,106
INSURANCE - PROP., LIAB., MALPRACTICE	26	5,000
ADMINISTRATIVE	17	(11,958)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
DUES, FEES & LICENSES	\$ 481	
FRANCHISE TAX	325	
SUBSCRIPTIONS	300	
LIABILITY INSURANCE DEDUCTIBLE	5,000	
BACKGROUND CHECKS	2,000	
CONTRACT WORKERS	3,852	
TOTAL	11,958	

MT. VERNON COUNTRYSIDE MANOR  
IDPH ID #0035998  
ATTACHMENT TO SCHEDULE XVII, LINE 28  
12/31/07

OTHER REVENUE:

BEAUTY SHOP	\$ 300
VOIDED CHECKS	1,070
TELEPHONE REFUND	100
COST REPORT SETTLEMENT	490
INCOME TAX REFUND	646
IDPA INTEREST	151
MISCELLANEOUS	1,034
FOOD REBATES	281
	<u>\$ 4,072</u>

MT. VERNON COUNTRYSIDE MANOR  
IDPH ID #0035998  
ATTACHMENT TO SCHEDULE XV, LINE 9  
12/31/07

OTHER ASSETS:

INVESTMENT IN LTC INSURANCE	\$ 20,705
UTILITY DEPOSIT	250
	<u>\$ 20,955</u>

MT. VERNON COUNTRYSIDE MANOR  
IDPH ID #0035998  
ATTACHMENT TO SCHEDULE XVII  
12/31/07

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 491,025
DEPRECIATION ADJUSTMENT	8,880
ILLINOIS REPLACEMENT TAXES	10,635
CONVERSION TO CASH BASIS ADJUSTMENTS	196,437
TAX NET INCOME	<u>\$ 706,977</u>