

Facility Name & ID Number Mt. Vernon Health Care Center

0047928 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 N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	25,403	5,361		30,764	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,403	5,361		30,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.51%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

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 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

NO

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

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

Facility Name & ID Number Mt. Vernon Health Care Center # 0047928 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				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
	A. General Services										
1	Dietary	108,679	11,948		120,627		120,627	2,574	123,201		1
2	Food Purchase		137,044		137,044		137,044	(1,751)	135,293		2
3	Housekeeping	129,807	16,177		145,984		145,984	29	146,013		3
4	Laundry	522	13,861		14,383		14,383	2	14,385		4
5	Heat and Other Utilities			91,324	91,324		91,324	440	91,764		5
6	Maintenance	35,279	8,404	14,262	57,945		57,945	4,305	62,250		6
7	Other (specify):* Home Off. Ben. All.							1,175	1,175		7
8	TOTAL General Services	274,287	187,434	105,586	567,307		567,307	6,774	574,081		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	980,342	57,513	2,263	1,040,118		1,040,118	6,807	1,046,925		10
10a	Therapy			950	950		950		950		10a
11	Activities	40,455	692	324	41,471		41,471		41,471		11
12	Social Services	21,104			21,104		21,104		21,104		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,513	1,513		15
16	TOTAL Health Care and Programs	1,041,901	58,205	12,537	1,112,643		1,112,643	8,320	1,120,963		16
	C. General Administration										
17	Administrative	97,810		130,000	227,810		227,810	(110,836)	116,974		17
18	Directors Fees										18
19	Professional Services			9,758	9,758		9,758	8,711	18,469		19
20	Dues, Fees, Subscriptions & Promotions			10,226	10,226		10,226	1,943	12,169		20
21	Clerical & General Office Expenses		4,654	7,813	12,467		12,467	51,787	64,254		21
22	Employee Benefits & Payroll Taxes			217,465	217,465		217,465	10,077	227,542		22
23	Inservice Training & Education			516	516		516	529	1,045		23
24	Travel and Seminar							840	840		24
25	Other Admin. Staff Transportation			4,116	4,116		4,116	4,819	8,935		25
26	Insurance-Prop.Liab.Malpractice			16,950	16,950		16,950	3,028	19,978		26
27	Other (specify):* Home Off. Ben. All.							12,477	12,477		27
28	TOTAL General Administration	97,810	4,654	396,844	499,308		499,308	(16,625)	482,683		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,998	250,293	514,967	2,179,258		2,179,258	(1,531)	2,177,727		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mt. Vernon Health Care Center

#0047928

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership											
30	Depreciation			81,599	81,599		81,599	(2,130)	79,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,725	72,725		72,725	23,261	95,986			32
33	Real Estate Taxes			3,257	3,257		3,257	1,007	4,264			33
34	Rent-Facility & Grounds							62	62			34
35	Rent-Equipment & Vehicles			10,334	10,334		10,334	836	11,170			35
36	Other (specify):*											36
37	TOTAL Ownership			167,915	167,915		167,915	23,036	190,951			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200		200		200		200			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* Non-allowable Cost	36,181	334	8,358	44,873		44,873	(44,873)				43
44	TOTAL Special Cost Centers	36,181	534	66,393	103,108		103,108	(44,873)	58,235			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,450,179	250,827	749,275	2,450,281		2,450,281	(23,368)	2,426,913			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.

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	(1,840)	2		4
5	Telephone, TV & Radio in Resident Rooms	(869)	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	(23,015)	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	(590)	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	(40,164)	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>	(1,113)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,841)		\$	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)	47,473	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 47,473		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (23,368)		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	TOTAL (C): (sum of lines 38-46)			\$	47

Mt. Vernon Health Care Center

ID# 0047928

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	\$ (1,113)	21	1
2				2
3				3
4				4
5				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	Total	(1,113)		49

STATE OF ILLINOIS

Summary A

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

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	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	2,574	0	0	0	0	0	0	0	0	0	2,574	1
2	Food Purchase	(1,840)	89	0	0	0	0	0	0	0	0	0	(1,751)	2
3	Housekeeping	0	29	0	0	0	0	0	0	0	0	0	29	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	440	0	0	0	0	0	0	0	0	0	440	5
6	Maintenance	0	3,586	0	719	0	0	0	0	0	0	0	4,305	6
7	Other (specify):*	0	1,175	0	0	0	0	0	0	0	0	0	1,175	7
8	TOTAL General Services	(1,840)	7,895	0	719	0	6,774	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,807	0	0	0	0	0	0	0	0	0	6,807	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	1,513	0	0	0	0	0	0	0	0	0	1,513	15
16	TOTAL Health Care and Programs	0	8,320	0	0	0	0	0	0	0	0	0	8,320	16
	C. General Administration													
17	Administrative	0	(110,836)	0	0	0	0	0	0	0	0	0	(110,836)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,202	0	3,509	0	0	0	0	0	0	0	8,711	19
20	Fees, Subscriptions & Promotions	0	0	1,127	816	0	0	0	0	0	0	0	1,943	20
21	Clerical & General Office Expenses	(1,113)	0	43,637	9,263	0	0	0	0	0	0	0	51,787	21
22	Employee Benefits & Payroll Taxes	0	0	0	10,077	0	0	0	0	0	0	0	10,077	22
23	Inservice Training & Education	0	0	502	27	0	0	0	0	0	0	0	529	23
24	Travel and Seminar	0	0	799	41	0	0	0	0	0	0	0	840	24
25	Other Admin. Staff Transportation	0	0	2,894	1,925	0	0	0	0	0	0	0	4,819	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,178	1,850	0	0	0	0	0	0	0	3,028	26
27	Other (specify):*	0	0	12,477	0	0	0	0	0	0	0	0	12,477	27
28	TOTAL General Administration	(1,113)	(105,634)	62,614	27,508	0	(16,625)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,953)	(89,419)	62,614	28,227	0	(1,531)	29						

STATE OF ILLINOIS

Summary B

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

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	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	(23,015)	0	3,056	17,829	0	0	0	0	0	0	0	(2,130)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	5,311	17,950	0	0	0	0	0	0	0	23,261	32
33	Real Estate Taxes	0	0	1,007	0	0	0	0	0	0	0	0	1,007	33
34	Rent-Facility & Grounds	0	0	62	0	0	0	0	0	0	0	0	62	34
35	Rent-Equipment & Vehicles	0	0	811	25	0	0	0	0	0	0	0	836	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,015)	0	10,247	35,804	0	23,036	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(44,873)	0	0	0	0	0	0	0	0	0	0	(44,873)	43
44	TOTAL Special Cost Centers	(44,873)	0	0	0	0	0	0	0	0	0	0	(44,873)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(70,841)	(89,419)	72,861	64,031	0	(23,368)	45						

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	100	See Attached Schedule 6E		See Attached Sch 6E		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,574	\$ 2,574	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	89	89	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	440	440	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,586	3,586	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,175	1,175	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,807	6,807	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,513	1,513	10
11	V	17 Administrative	130,000	Petersen Health Care, Inc.	100.00%	19,164	(110,836)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,202	5,202	12
13	V							13
14	Total		\$ 130,000			\$ 40,581	\$ * (89,419)	14

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

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	20 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 1,127	\$	1,127	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	43,637		43,637	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	502		502	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	799		799	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,894		2,894	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,178		1,178	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	12,477		12,477	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,056		3,056	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,311		5,311	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,007		1,007	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	62		62	25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	811		811	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		\$			\$ 72,861	\$ *	72,861	39

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

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	1 <u>Dietary</u>	\$	<u>Petersen Health Care II, Inc.</u>	100.00%	\$ 0	\$ 0
16	V	2 <u>Food</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
18	V	4 <u>Laundry</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
19	V	5 <u>Utilities</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	719	719
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
23	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
24	V	17 <u>Administrative</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
25	V	19 <u>Professional Services</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	3,509	3,509
26	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	816	816
27	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	9,263	9,263
28	V	22 <u>Employee Benefits & PR Taxes</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	10,077	10,077
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	27	27
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	41	41
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	1,925	1,925
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	1,850	1,850
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	17,829	17,829
35	V	32 <u>Interest</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	17,950	17,950
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0	0
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	25	25
39	Total		\$			\$ 64,031	\$ * 64,031

* 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:

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.26	2.29	Salary	\$ 19,164	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	\$ 19,164		13

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

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

Facility Name & ID Number Mt. Vernon Health Care Center# 0047928 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 Petersen Health Care, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	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	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	30,764	\$ 2,574	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	30,764	89	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	30,764	29	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	30,764	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	30,764	440	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	30,764	3,586	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	30,764	1,175	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	30,764	6,807	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	30,764	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	30,764	1,513	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	30,764	19,164	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	30,764	5,202	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	30,764	1,127	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	30,764	43,637	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	30,764	502	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	30,764	799	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	30,764	2,894	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	30,764	1,178	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	30,764	12,477	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	30,764	3,056	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	30,764	5,311	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	30,764	1,007	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	30,764	62	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	30,764	811	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 113,442	25

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

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

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

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

1	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	Resident Days	340,686	11	\$	30,764	\$	1
2	2	Food	Resident Days	340,686	11		30,764		2
3	3	Housekeeping	Resident Days	340,686	11		30,764		3
4	4	Laundry	Resident Days	340,686	11		30,764		4
5	5	Utilities	Resident Days	340,686	11		30,764		5
6	6	Maintenance	Resident Days	340,686	11	7,966	30,764	719	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		30,764		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		30,764		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		30,764		9
10	17	Administrative	Resident Days	340,686	11		30,764		10
11	19	Professional Services	Resident Days	340,686	11	38,857	30,764	3,509	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	30,764	816	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	30,764	9,263	13
14	22	Employee Benefits & PR Taxes	Resident Days	340,686	11	111,591	30,764	10,077	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	30,764	27	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	30,764	41	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	30,764	1,925	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	30,764	1,850	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		30,764		19
20	30	Depreciation	Resident Days	340,686	11	197,442	30,764	17,829	20
21	32	Interest	Resident Days	340,686	11	198,787	30,764	17,950	21
22	33	Real Estate Taxes	Resident Days	340,686	11		30,764		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		30,764		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	30,764	25	24
25	TOTALS					\$ 709,099	\$	\$ 64,031	25

Facility Name & ID Number

Mt. Vernon Health Care Center

0047928

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	US Bank		X	Mortgage	Varies	12/09/04	\$ 3,660,000	\$ 867,538	11/09/11	0.0699	\$ 72,445	1					
2												2					
3												3					
4							Home Office Allocation				23,261	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 3,660,000	\$ 867,538			\$ 95,706	9					
B. Non-Facility Related*																	
10												10					
11							Amortization of Loan Costs				280	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 280	14					
15	TOTALS (line 9+line14)						\$ 3,660,000	\$ 867,538			\$ 95,986	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.)

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

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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 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>06-36-126-015</u>	<u>Long-Term Care Facility</u>	\$ <u>16,256.76</u>	\$ <u>16,256.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>16,256.76</u>	\$ <u>16,256.76</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 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 & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>120,000</u>	<u>2005</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	120,000		\$ 60,000	3

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	\$	25	\$ 24,142	\$ 24,142	\$ 47,952
5									
6									
7	Home Office Allocation			17,151			419	419	
8									
Improvement Type**									
9	Original Land improvements		2006	15,000		15	1,000	1,000	2,249
10	Durolast		2006	26,843		20	1,342	1,342	2,013
11	Sign front door		2006	3,118		20	156	156	234
12	Fire Alarm		2007	2,222		15	74	74	74
13	Roof Top Air Conditioner		2007	4,990		15	166	166	166
14									
15									
16									
17									
18	Land improvement booked				1,000			(1,000)	
19	Building booked				47,620			(47,620)	
20	Building improvement booked				491			(491)	
21	Equipment booked								
22									
23									
24									
25									
26									
27									
28									
29									
30	2007-Home Office Allocation-Land Improvements			1,148			68	68	
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

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)	\$ 1,260,972	\$ 49,111		\$ 27,367	\$ (21,744)	\$ 52,688	70

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

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 216,236	\$ 31,364	\$ 30,990	\$ (374)	5-10	\$ 46,616	71
72	Current Year Purchases	14,279	1,124	714	(410)	10	714	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			20,398	20,398			74
75	TOTALS	\$ 230,515	\$ 32,488	\$ 52,102	\$ 19,614		\$ 47,330	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				\$	\$	\$	\$		\$	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)	\$ 1,551,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,599	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,469	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,130)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 100,018	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 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		Home Office Allocation			62			6
7	TOTAL				\$ 62			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: \$ 11,170 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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 \$ _____

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

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

Mt. Vernon Health Care Center

0047928

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$	4,015
Dishwasher		735
Laundry Equipment		2,304
Medical Equipment		3,280
Home Office Allocation		836
		<u>11,170</u>

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	L. 10A, C. 3	hrs	\$	63	\$ 950	\$	63	\$ 950	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				200		200	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	TOTAL			\$	63	\$ 950	\$ 200	63	\$ 1,150	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (271,128)	\$ (271,128)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	396,203	396,203	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,395	16,395	6
7	Other Prepaid Expenses	3,535	3,535	7
8	Accounts Receivable (owners or related parties)	15,120	15,120	8
9	Other(specify): <u>Security Deposit</u>	3,840	3,840	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 163,965	\$ 163,965	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	1,265,500	1,208,799	14
15	Leasehold Improvements, at Historical Cost	7,212	52,173	15
16	Equipment, at Historical Cost	233,633	230,515	16
17	Accumulated Depreciation (book methods)	(130,591)	(100,018)	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): <u>Loan Costs</u>	1,120	1,120	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,376,874	\$ 1,452,589	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,540,839	\$ 1,616,554	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 220,366	\$ 220,366	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,410	92,410	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,205	7,205	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,000	17,000	32
33	Accrued Interest Payable	6,071	6,071	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued expenses</u>	23,561	23,561	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 366,613	\$ 366,613	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	867,538	867,538	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Owner</u>	13,743	13,743	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 881,281	\$ 881,281	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,247,894	\$ 1,247,894	46
47	TOTAL EQUITY(page 18, line 24)	\$ 292,945	\$ 368,660	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,540,839	\$ 1,616,554	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 93,486	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 93,487	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,458	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 199,458	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 292,945	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,646,741	1
2	Discounts and Allowances for all Levels	(358)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,646,383	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,840	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,840	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue- See Sch. 19A</u>	1,516	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,516	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,649,739	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	567,307	31
32	Health Care	1,112,643	32
33	General Administration	499,308	33
	B. Capital Expense		
34	Ownership	167,915	34
	C. Ancillary Expense		
35	Special Cost Centers	45,073	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,450,281	40
41	Income before Income Taxes (line 30 minus line 40)**	199,458	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,458	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. Facility is a division of a larger entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Mt. Vernon Health Care Center

0047928

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Gain on Sale of Property 403

Office Supplies 1,113

1,516

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning: 01/01/2007

Ending: 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	2,080	2,080	\$ 42,436	\$ 20.40	1
2	Assistant Director of Nursing	953	953	16,239	17.04	2
3	Registered Nurses	3,225	3,281	57,449	17.51	3
4	Licensed Practical Nurses	18,122	18,439	293,632	15.92	4
5	CNAs & Orderlies	58,055	59,477	515,150	8.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,997	2,062	20,336	9.86	9
10	Activity Assistants	2,383	2,447	20,119	8.22	10
11	Social Service Workers	2,080	2,080	21,104	10.15	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,735	11.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,149	11,508	84,944	7.38	15
16	Dishwashers					16
17	Maintenance Workers	2,363	2,410	35,279	14.64	17
18	Housekeepers	16,764	16,964	129,807	7.65	18
19	Laundry	75	75	522	6.96	19
20	Administrator	2,080	2,080	52,984	25.47	20
21	Assistant Administrator	3,797	3,856	44,826	11.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	5,083	5,083	91,617	18.02	33
34	TOTAL (lines 1 - 33)	132,286	134,875	\$ 1,450,179 *	\$ 10.75	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			35
36	Medical Director	Monthly 9,000	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	L. 10, C. 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)	\$ 10,200		49

C. CONTRACT NURSES

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

Mt. Vernon Health Care Center
0047928
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,884	1,884	33,942	18.02
Marketing	1,986	1,986	36,181	18.22
Alzheimer's Coordinator	1,213	1,213	21,494	17.72
Total Line 32-Other	5,083	5,083	91,617	18.02

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	\$ 52,984	Workers' Compensation Insurance	\$ 8,951	IDPH License Fee	\$ 973	
Lisa Dickey	Asst. Administrator	0	16,897	Unemployment Compensation Insurance	40,382	Advertising: Employee Recruitment	1,859	
Fay Watson	Asst. Administrator	0	27,929	FICA Taxes	107,633	Health Care Worker Background Check (Indicate # of checks performed <u>146</u>)	1,460	
				Employee Health Insurance	61,475			
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	3,750	
						LTC Solutions License	1,600	
				Employee Relations	9,101	Miscellaneous Dues & Subscriptions	584	
						Home Office Allocation	1,943	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,810			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 130,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 130,000					
C. Professional Services				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
Charter Communications	Computer Services		\$ 585				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,093					
McGladrey & Pullen, LLP	Accounting		7,080	N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	840
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,758	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 840

* Attach copy of IMRF notifications

**See instructions.

Mt. Vernon Health Care Center
0047928
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

**XIX. SUPPORT SCHEDULE
C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,758

Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	34
Addy Bush & Assoc	Legal	17
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	75
Duane Morris	Legal	117
Ginoli & Co.	Accountants	1,189
RSM McGladrey	Accountants	206
McGladrey & Pullen	Accountants	314
Emdeon Business Services	Computer Services	82
Advanced Answers on Demand	Computer Services	2,206
Access 2 Go	Computer Services	166
Ivans	Computer Services	146
Kemper Technology	Computer Services	346
Adminastar Federal	Computer Services	43
Logmein	Computer Services	27
E-Health Data Solutions	Computer Services	216
Miscellaneous Vendors	Miscellaneous	15

Petersen Health Care II, Inc.

Ginoli & Co.	Accountants	2,706
Ivans	Computer Services	575
CDW	Computer Services	174
Miscellaneous Vendors	Computer Services	54

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>18,469</u>
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Facility Name & ID Number Mt. Vernon Health Care Center

0047928

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 \$3750
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,113 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. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,840
- (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? N/A
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 currently 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 \$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