



Facility Name & ID Number Mt. Vernon Health Care Center

# 0047928 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	38,796	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	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	
8	SNF				8
9	SNF/PED				9
10	ICF	23,322	6,884		30,206
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	23,322	6,884		30,206

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.86%

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Mt. Vernon Health Care Center # 0047928 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	114,932	12,697		127,629		127,629	5,369	132,998		1
2	Food Purchase		145,649		145,649		145,649	(2,792)	142,857		2
3	Housekeeping	151,118	20,256		171,374		171,374	40	171,414		3
4	Laundry		10,066		10,066		10,066	2	10,068		4
5	Heat and Other Utilities			90,735	90,735		90,735	1,938	92,673		5
6	Maintenance	36,558	5,584	12,943	55,085		55,085	3,281	58,366		6
7	Other (specify):* Home Off. Ben. All.							1,320	1,320		7
8	<b>TOTAL General Services</b>	<b>302,608</b>	<b>194,252</b>	<b>103,678</b>	<b>600,538</b>		<b>600,538</b>	<b>9,158</b>	<b>609,696</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,053,809	52,456	16,328	1,122,593		1,122,593	8,375	1,130,968		10
10a	Therapy										10a
11	Activities	38,670	185	487	39,342		39,342		39,342		11
12	Social Services	17,262			17,262		17,262		17,262		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,627	1,627		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,109,741</b>	<b>52,641</b>	<b>25,815</b>	<b>1,188,197</b>		<b>1,188,197</b>	<b>10,002</b>	<b>1,198,199</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	66,504		137,000	203,504		203,504	(95,204)	108,300		17
18	Directors Fees										18
19	Professional Services			5,395	5,395		5,395	11,000	16,395		19
20	Dues, Fees, Subscriptions & Promotions			9,061	9,061		9,061	3,686	12,747		20
21	Clerical & General Office Expenses	26,035	5,700	10,768	42,503		42,503	60,390	102,893		21
22	Employee Benefits & Payroll Taxes			394,836	394,836		394,836	1,051	395,887		22
23	Inservice Training & Education							319	319		23
24	Travel and Seminar			810	810		810	437	1,247		24
25	Other Admin. Staff Transportation			4,555	4,555		4,555	6,830	11,385		25
26	Insurance-Prop.Liab.Malpractice			21,452	21,452		21,452	1,892	23,344		26
27	Other (specify):* Home Off. Ben. All.							14,932	14,932		27
28	<b>TOTAL General Administration</b>	<b>92,539</b>	<b>5,700</b>	<b>583,877</b>	<b>682,116</b>		<b>682,116</b>	<b>5,333</b>	<b>687,449</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,504,888</b>	<b>252,593</b>	<b>713,370</b>	<b>2,470,851</b>		<b>2,470,851</b>	<b>24,493</b>	<b>2,495,344</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.

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

Facility Name &amp; ID Number

Mt. Vernon Health Care Center

#0047928

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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			86,124	86,124		86,124	2,920	89,044			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,673	70,673		70,673	34,407	105,080			32
33	Real Estate Taxes			17,302	17,302		17,302	767	18,069			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,422	15,422		15,422	813	16,235			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			189,521	189,521		189,521	38,907	228,428			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):* Non-allowable Cost	35,000	675	30,504	66,179		66,179	(66,179)				43
44	<b>TOTAL Special Cost Centers</b>	35,000	675	88,698	124,373		124,373	(66,179)	58,194			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,539,888	253,268	991,589	2,784,745		2,784,745	(2,779)	2,781,966			45

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

**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				4
5	Telephone, TV & Radio in Resident Rooms	(712)	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	(24,366)	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	(206)	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	(12,884)	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	(15,790)	43		24
25	Fund Raising, Advertising and Promotional	(36,450)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(4,130)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (94,538)		\$	30

BHF USE ONLY							
48		49		50		51	

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
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	91,759	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 91,759		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,779)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Mt. Vernon Health Care Center

ID# 0047928

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (40)	43	1
2	Resident Flowers	(56)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(943)	10	3
4	Offset Miscellaneous Food Revenue	(2,880)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(170)	21	5
6	Disallowed Special Events	(41)	43	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
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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>	(4,130)		49

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,369	\$ 5,369	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	88	88	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	40	40	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	556	556	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,281	3,281	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,320	1,320	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,318	9,318	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,627	1,627	10
11	V	17 Administrative	137,000	Petersen Health Care, Inc.	100.00%	41,796	(95,204)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,717	4,717	12
13	V							13
14	Total					\$ 68,114	\$ * (68,886)	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 Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,455	\$	1,455	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	52,450		52,450	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	319		319	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	319		319	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,130		4,130	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	251		251	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,932		14,932	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,714		5,714	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,020		4,020	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	767		767	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	653		653	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		\$			\$ 85,010	\$ *	85,010	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 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,382	1,382	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	6,283	6,283	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,231	2,231	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	8,110	8,110	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,051	1,051	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	118	118	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,700	2,700	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,641	1,641	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	21,572	21,572	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	30,387	30,387	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	160	160	38	
39	<b>Total</b>		\$			\$ 75,635	\$ *	75,635	39

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

Facility Name &amp; ID Number

Mt. Vernon Health Care Center

# 0047928

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	1,786,878	1.25	2.09	Salary	\$ 41,796	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	\$ 41,796		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:

1/1/2008Ending: 2/31/2008

## 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	1,413,604	69	\$ 251,260	\$ 250,687	30,206	\$ 5,369	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	30,206	88	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	30,206	40	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	30,206	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	30,206	556	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	30,206	3,281	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	30,206	1,320	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	30,206	9,318	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	30,206	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	30,206	1,627	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	30,206	41,796	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	30,206	4,717	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	30,206	1,455	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	30,206	52,450	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	30,206	319	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	30,206	319	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	30,206	4,130	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	30,206	251	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	30,206	14,932	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	30,206	5,714	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	30,206	4,020	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	30,206	767	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	30,206	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	30,206	653	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 153,124	25

Facility Name & ID Number Mt. Vernon Health Care Center

# 0047928

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

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 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

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	331,413	13	\$	30,206	\$	1
2	2	Food	Resident Days	331,413	13		30,206		2
3	3	Housekeeping	Resident Days	331,413	13		30,206		3
4	4	Laundry	Resident Days	331,413	13		30,206		4
5	5	Utilities	Resident Days	331,413	13		30,206		5
6	6	Maintenance	Resident Days	331,413	13	15,163	30,206	1,382	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,206		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		30,206		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,206		9
10	17	Administrative	Resident Days	331,413	13		30,206		10
11	19	Professional Services	Resident Days	331,413	13	68,939	30,206	6,283	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	30,206	2,231	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	30,206	8,110	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	30,206	1,051	14
15	23	Inservice Training & Education	Resident Days	331,413	13		30,206		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	30,206	118	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	30,206	2,700	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	30,206	1,641	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,206		19
20	30	Depreciation	Resident Days	331,413	13	236,686	30,206	21,572	20
21	32	Interest	Resident Days	331,413	13	333,393	30,206	30,387	21
22	33	Real Estate Taxes	Resident Days	331,413	13		30,206		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		30,206		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	30,206	160	24
25	TOTALS					\$ 829,849	\$	\$ 75,635	25

Facility Name & ID Number

Mt. Vernon Health Care Center

# 0047928

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	US Bank		X	Mortgage	Varies	12/09/04	\$ 3,660,000	\$ 843,537	11/09/11	0.0699	\$ 70,393	1						
2												2						
3												3						
4							Home Office Allocation-PHC				4,020	4						
5							Home Office Allocation-PHC II				30,387	5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 3,660,000	\$ 843,537			\$ 104,800	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11							Amortization of Loan Costs				280	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 280	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,660,000	\$ 843,537			\$ 105,080	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.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2007 report.		\$	<b>17,000</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.)	2007	\$	<b>16,802</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(198)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>17,500</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>Home Office Allocation</b>			<b>767</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>18,069</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	<b>16,257</b>	11
	2007	<b>16,802</b>	12

**Accrual based on prior year tax bill.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>16,801.62</u>	\$ <u>16,801.62</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>16,801.62</u>	\$ <u>16,801.62</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

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

Facility Name & ID Number Mt. Vernon Health Care Center

# 0047928

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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	\$ 72,094	4
5										5
6										6
7	Home Office Allocation									7
8										8
	<b>Improvement Type**</b>									
9	Original Land Improvements		2006	15,000		15	1,000	1,000	3,249	9
10	Durolast		2006	26,843		20	1,342	1,342	3,355	10
11	Sign front door		2006	3,118		20	156	156	390	11
12	Fire Alarm		2007	2,222		15	148	148	222	12
13	Roof Top Air Conditioner		2007	4,990		15	333	333	499	13
14	Sprinkler System		2008	86,980		39	1,115	1,115	1,115	14
15	Furnace		2008	6,600		5	660	660	660	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	Building Booked				47,620			(47,620)		28
29	Building Improvement Booked				4,487			(4,487)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			1,049			68	68		32
33	2008-Home Office Allocation-Building Improvements			15,684			376	376		33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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)	\$ 1,352,986	\$ 52,107		\$ 29,340	\$ (22,767)	\$ 81,584	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:

1/1/2008

Ending:

12/31/2008

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	\$ 230,515	\$ 34,017	\$ 32,418	\$ (1,599)	7-10 yrs.	\$ 79,748	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			27,286	27,286			74
75	TOTALS	\$ 230,515	\$ 34,017	\$ 59,704	\$ 25,687		\$ 79,748	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)	\$ 1,643,501	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,044	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,920	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 161,332	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	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?

If NO, see instructions.  YES  NO

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

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

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

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

**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: \$ 9,354 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 688.00	\$ 6,881	17
18					18
19					19
20					20
21	TOTAL		\$ 688.00	\$ 6,881	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 1/1/2008**

**Period End 12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 1,831
Dishwasher	708
Laundry Equipment	2,087
Copier	3,915
Home Office Allocation	813
	<u>9,354</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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (322,357)	\$ (322,357)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	555,413	555,413	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,253	26,253	6
7	Other Prepaid Expenses	12,012	12,012	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 271,321	\$ 271,321	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	1,265,500	1,206,184	14
15	Leasehold Improvements, at Historical Cost	100,792	146,802	15
16	Equipment, at Historical Cost	233,633	230,515	16
17	Accumulated Depreciation (book methods)	(216,715)	(161,332)	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> )	841	841	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,384,051	\$ 1,483,010	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,655,372	\$ 1,754,331	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 245,381	\$ 245,381	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,482	94,482	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,608	5,608	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,500	17,500	32
33	Accrued Interest Payable	5,660	5,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued expenses</u>	66,621	66,621	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 435,252	\$ 435,252	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	843,537	843,537	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Due to Prior Owner</u>	2,605	2,605	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 846,142	\$ 846,142	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,281,394	\$ 1,281,394	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 373,978	\$ 472,937	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,655,372	\$ 1,754,331	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>292,945</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>292,945</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>81,033</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>81,033</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>373,978</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,813,356	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,813,356	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,880	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,880	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Insurance Proceeds from Tornado Damages	48,429	28
28a	Miscellaneous Revenue	1,113	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 49,542	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,865,778	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	600,538	31
32	Health Care	1,188,197	32
33	General Administration	682,116	33
	<b>B. Capital Expense</b>		
34	Ownership	189,521	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	66,179	35
36	Provider Participation Fee	58,194	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,784,745	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	81,033	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 81,033	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 part of 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.

Facility Name & ID Number Mt. Vernon Health Care Center

# 0047928

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

**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	1,606	1,606	\$ 33,979	\$ 21.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,569	4,580	24,742	5.40	3
4	Licensed Practical Nurses	21,272	21,566	357,265	16.57	4
5	CNAs & Orderlies	57,287	58,397	557,997	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	1,973	19,930	10.10	9
10	Activity Assistants	2,123	2,194	18,740	8.54	10
11	Social Service Workers	2,080	2,080	17,262	8.30	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,016	23,646	11.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,608	11,987	91,286	7.62	15
16	Dishwashers					16
17	Maintenance Workers	2,110	2,158	36,558	16.94	17
18	Housekeepers	18,118	18,389	151,118	8.22	18
19	Laundry					19
20	Administrator	2,080	2,080	48,753	23.44	20
21	Assistant Administrator	1,722	1,809	17,751	9.81	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	26,035	12.52	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>	6,103	6,103	114,826	18.81	33
34	TOTAL (lines 1 - 33)	136,681	139,018	\$ 1,539,888 *	\$ 11.08	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	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,000		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	10	\$ 450	10(3)	50
51	Licensed Practical Nurses	342	13,700	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	352	\$ 14,150		53

**Mt. Vernon Health Care Center**  
**0047928**  
**Period Beginning 1/1/2008**  
**Period End 12/31/2008**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs.</b>	<b># of Hrs.</b>	<b>Reporting</b>	
	<b>Actually</b>	<b>Paid and</b>	<b>Period</b>	<b>Average</b>
	<b>Worked</b>	<b>Accrued</b>	<b>Total</b>	<b>Hourly</b>
			<b>Salaries,</b>	<b>Wage</b>
			<b>Wages</b>	
<b>Care Plan Coordinator</b>	2,080	2,080	40,164	19.31
<b>Marketing</b>	2,080	2,080	35,000	16.83
<b>Alzheimer's Coordinator</b>	1,943	1,943	39,662	20.41
<b>TOTAL (lines 1 - 35)</b>	<u>6,103</u>	<u>6,103</u>	<u>114,826</u>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carrell Breeze	Administrator	0	\$ 48,753	Workers' Compensation Insurance	\$ 107,114	IDPH License Fee	\$ 995	
Lisa Dickey	Administrator	0	17,751	Unemployment Compensation Insurance	35,547	Advertising: Employee Recruitment	2,577	
				FICA Taxes	115,173	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	136,018	Patient Background Checks	204 2,040	
				Employee Meals		Miscellaneous Licenses & Permits	300	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	49	
				Employee Relations	2,035	IHCA Dues	3,100	
						Home Office Allocation	3,686	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,504			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			\$ 137,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 137,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 395,887	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,747	
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		\$ 1,005				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,790					
LTC Solutions	Computer Services		1,600				In-State Travel	
				N/A				
							Seminar Expense	810
							Home Office Allocation	437
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,395	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,247

\* Attach copy of IMRF notifications

\*\*See instructions.

**Mt. Vernon Health Care Center**

**0047928**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		5,395

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	171
GoffWilson, P.A.	Legal	573
U.S. Bank	Legal	999
Ginoli & Company	Accountants	5,033
RSM McGladrey	Accountants	13
U.S. Bank	Accountants	613
Miscellaneous Vendors	Computer Services	67
Emdeon Business Services	Computer Services	92
Advanced Answers on Demand	Computer Services	1,084
Access 2 Go	Computer Services	320
Ivans	Computer Services	890
Kemper Technology	Computer Services	587
VisionShare	Computer Services	63
Logmeln	Computer Services	45
Comm Net Communiations	Computer Services	17
Charter Communications	Computer Services	14
Advanced System Designs	Computer Services	21
Consolidated Communications	Computer Services	13
CDW	Computer Services	305
Miscellaneous Vendors	Miscellaneous	80

Total (agree to Schedule V, line 19, column 8)	<u>16,395</u>
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**Mt. Vernon Health Care Center**

**0047928**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>
Carrell Breeze	Administrator	0	48,753
Lisa Dickey	Asst. Administrator	0	17,751
	<b>Total</b>		<u>66,504</u>



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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 3,100 -IHCA
- (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? No
- (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. \$ 10,539 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? N/A  
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. \$ 58,194  
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. \$ 2,880
- (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. \$ No
- 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company 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