

Facility Name & ID Number Mt. Vernon Health Care Center

0047928 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	20,861	6,325	574	27,760	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,861	6,325	574	27,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.75%

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 3/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/2006 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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Mt. Vernon Health Care Center # 0047928 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	114,898	11,514		126,412		126,412	4,855	131,267		1
2	Food Purchase		147,753		147,753		147,753	(3,131)	144,622		2
3	Housekeeping	156,839	23,636		180,475		180,475	46	180,521		3
4	Laundry		8,238		8,238		8,238		8,238		4
5	Heat and Other Utilities			89,139	89,139		89,139	479	89,618		5
6	Maintenance	34,679	7,691	13,508	55,878		55,878	2,403	58,281		6
7	Other (specify):* Home Off. Ben. All.							877	877		7
8	TOTAL General Services	306,416	198,832	102,647	607,895		607,895	5,529	613,424		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,120,360	60,814	2,001	1,183,175		1,183,175	2,744	1,185,919		10
10a	Therapy		61		61		61		61		10a
11	Activities	37,712	124	75	37,911		37,911		37,911		11
12	Social Services	23,042			23,042		23,042		23,042		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							362	362		15
16	TOTAL Health Care and Programs	1,181,114	60,999	11,076	1,253,189		1,253,189	3,106	1,256,295		16
	C. General Administration										
17	Administrative	29,908		211,000	240,908		240,908	(166,710)	74,198		17
18	Directors Fees										18
19	Professional Services			5,395	5,395		5,395	18,285	23,680		19
20	Dues, Fees, Subscriptions & Promotions			5,452	5,452		5,452	3,298	8,750		20
21	Clerical & General Office Expenses	32,422	4,985	11,345	48,752		48,752	58,167	106,919		21
22	Employee Benefits & Payroll Taxes			267,165	267,165		267,165	7,125	274,290		22
23	Inservice Training & Education							708	708		23
24	Travel and Seminar							156	156		24
25	Other Admin. Staff Transportation			5,024	5,024		5,024	6,012	11,036		25
26	Insurance-Prop.Liab.Malpractice			34,843	34,843		34,843	1,012	35,855		26
27	Other (specify):* Home Off. Ben. All.							13,287	13,287		27
28	TOTAL General Administration	62,330	4,985	540,224	607,539		607,539	(58,660)	548,879		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,549,860	264,816	653,947	2,468,623		2,468,623	(50,025)	2,418,598		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:

1/1/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			89,798	89,798		89,798	3,219	93,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,013	69,013		69,013	26,841	95,854			32
33	Real Estate Taxes			18,185	18,185		18,185	615	18,800			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,331	16,331		16,331	590	16,921			35
36	Other (specify):*											36
37	TOTAL Ownership			193,327	193,327		193,327	31,265	224,592			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107		107		107		107			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	8,750	26	3,956	12,732		12,732	(12,732)				43
44	TOTAL Special Cost Centers	8,750	133	61,991	70,874		70,874	(12,732)	58,142			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,558,610	264,949	909,265	2,732,824		2,732,824	(31,492)	2,701,332			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	(751)	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	(24,947)	30		9
10	Interest and Other Investment Income	(3,797)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(222)	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		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	(989)	43		24
25	Fund Raising, Advertising and Promotional	(9,571)	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 See Pg. 5A	(4,821)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,098)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,606	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,606		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (31,492)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Mt. Vernon Health Care Center

ID# 0047928

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Nursing Supplies Revenue	(194)	10	1
2	Offset Miscellaneous Food Revenue	(3,240)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(188)	21	3
4	Disallowed Special Events	(1,199)	43	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	(4,821)		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:	
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%	\$ 4,855	\$ 4,855	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	109	109	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	479	479	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,351	2,351	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	877	877	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,938	2,938	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%	362	362	10
11	V	17 Administrative	211,000	Petersen Health Care, Inc.	100.00%	44,290	(166,710)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,807	6,807	12
13	V							13
14	Total		\$ 211,000			\$ 63,114	\$ * (147,886)	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 Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,897	\$	1,897	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	49,502		49,502	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	505		505	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	156		156	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,439		2,439	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,012		1,012	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,287		13,287	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,001		4,001	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,154		6,154	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	615		615	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%	588		588	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		\$			\$ 80,156	\$ *	80,156	39

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

Facility Name & ID Number Mt. Vernon Health Care Center# 0047928Report Period Beginning: 1/1/2009Ending: 12/31/2009

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%	52		52 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%	11,478		11,478 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,401		1,401 26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	8,853		8,853 27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	7,125		7,125 28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	203		203 29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,573		3,573 31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		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%	24,165		24,165 34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	24,484		24,484 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%	2		2 38
39	Total		\$			\$ 81,336	\$ *	81,336 39

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

Facility Name & ID Number

Mt. Vernon Health Care Center

0047928

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	155,957	1.08	1.80	Salary	\$ 3,156	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	\$ 3,156		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:

1/1/2009

Ending: 2/31/2009

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, 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	1,493,044	75	\$ 261,102	\$ 259,584	27,760	\$ 4,855	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	27,760	109	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	27,760	46	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	27,760	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	27,760	479	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	27,760	2,351	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	27,760	877	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	27,760	2,938	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	27,760	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	27,760	362	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	27,760	44,290	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	27,760	6,807	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	27,760	1,897	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	27,760	49,502	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	27,760	505	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	27,760	156	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	27,760	2,439	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	27,760	1,012	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	27,760	13,287	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	27,760	4,001	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	27,760	6,154	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	27,760	615	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	27,760	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	27,760	588	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 143,270	25

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	336,837	13	\$	\$	27,760	\$	1
2	2	Food	Resident Days	336,837	13			27,760		2
3	3	Housekeeping	Resident Days	336,837	13			27,760		3
4	4	Laundry	Resident Days	336,837	13			27,760		4
5	5	Utilities	Resident Days	336,837	13			27,760		5
6	6	Maintenance	Resident Days	336,837	13	628		27,760	52	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13			27,760		7
8	10	Nursing and Medical Records	Resident Days	336,837	13			27,760		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13			27,760		9
10	17	Administrative	Resident Days	336,837	13			27,760		10
11	19	Professional Services	Resident Days	336,837	13	139,269		27,760	11,478	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001		27,760	1,401	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426		27,760	8,853	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458		27,760	7,125	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464		27,760	203	15
16	24	Travel and Seminar	Resident Days	336,837	13			27,760		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354		27,760	3,573	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13			27,760		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13			27,760		19
20	30	Depreciation	Resident Days	336,837	13	293,215		27,760	24,165	20
21	32	Interest	Resident Days	336,837	13	297,084		27,760	24,484	21
22	33	Real Estate Taxes	Resident Days	336,837	13			27,760		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13			27,760		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26		27,760	2	24
25	TOTALS					\$ 986,925	\$		\$ 81,336	25

Facility Name & ID Number

Mt. Vernon Health Care Center

0047928

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	US Bank		X	Mortgage	Varies	12/09/04	\$ 3,660,000	\$ 818,120	11/09/11	0.0699	\$ 68,733	1							
2												2							
3							Interest Income Offset				(3,797)	3							
4							Home Office Allocation-PHC				6,154	4							
5							Home Office Allocation-PHC II				24,484	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,660,000	\$ 818,120			\$ 95,574	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	\$ 818,120			\$ 95,854	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.)

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	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	\$ 96,236
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements		2006	15,000		15	1,000	1,000	4,249
10	Durolast		2006	26,843		20	1,342	1,342	4,697
11	Sign front door		2006	3,118		20	156	156	546
12	Fire Alarm		2007	2,222		15	148	148	370
13	Roof Top Air Conditioner		2007	4,990		15	333	333	832
14	Sprinkler System		2008	86,980		39	2,230	2,230	3,345
15	Furnace		2008	6,600		5	1,320	1,320	1,980
16	Sewer Line Repair		2009	10,514		7	751	751	751
17	Sidewalks		2009	8,930		15	298	298	298
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				1,446			(1,446)	
28	Building Booked				47,620			(47,620)	
29	Building Improvement Booked				6,368			(6,368)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			913			57	57	
33	2009-Home Office Allocation-Building Improvements			13,647			327	327	
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)	\$ 1,370,257	\$ 55,434		\$ 32,104	\$ (23,330)	\$ 113,304	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 230,515	\$ 34,017	\$ 32,418	\$ (1,599)	7-10 yrs.	\$ 112,166	71
72	Current Year Purchases	6,589	347	329	(18)	10 yrs.	329	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			28,166	28,166			74
75	TOTALS	\$ 237,104	\$ 34,364	\$ 60,913	\$ 26,549		\$ 112,495	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)	\$ 1,667,361	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,798	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,017	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,219	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 225,799	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: \$ 8,664 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	\$ 8,257	17
18					18
19					19
20					20
21	TOTAL		\$ 688.00	\$ 8,257	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 1/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	2,661
Dishwasher		849
Laundry Equipment		2,388
Copier		2,176
Home Office Allocation		590
		<u>8,664</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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				61		61	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				107		107	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	TOTAL			\$		\$	168	\$	168	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# 0047928Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 160,966	\$ 160,966	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	148,690	148,690	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,840	52,840	6
7	Other Prepaid Expenses	12,636	12,636	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 375,132	\$ 375,132	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	1,274,430	1,204,147	14
15	Leasehold Improvements, at Historical Cost	111,306	166,110	15
16	Equipment, at Historical Cost	240,222	237,104	16
17	Accumulated Depreciation (book methods)	(306,514)	(225,799)	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 (spe <u>Loan Costs</u>)	561	561	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,320,005	\$ 1,442,123	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,695,137	\$ 1,817,255	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 175,882	\$ 175,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,196	97,196	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,073	4,073	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,100	18,100	32
33	Accrued Interest Payable	6,103	6,103	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	66,105	66,105	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 367,459	\$ 367,459	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	818,120	818,120	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Owner</u>	2,621	2,621	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 820,741	\$ 820,741	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,188,200	\$ 1,188,200	46
47	TOTAL EQUITY(page 18, line 24)	\$ 506,937	\$ 629,055	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,695,137	\$ 1,817,255	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 373,978	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 373,975	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,962	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)	\$ 132,962	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)	\$ 506,937	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	\$ 2,858,367	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,858,367	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	3,240	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)	\$ 3,240	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,797	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	382	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 382	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,865,786	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	607,895	31
32	Health Care	1,253,189	32
33	General Administration	607,539	33
B. Capital Expense			
34	Ownership	193,327	34
C. Ancillary Expense			
35	Special Cost Centers	12,839	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)*	\$ 2,732,824	40
41	Income before Income Taxes (line 30 minus line 40)**	132,962	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 132,962	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:

1/1/2009

Ending:

12/31/2009

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	\$ 57,202	\$ 27.50	1
2	Assistant Director of Nursing	46	46	761	16.54	2
3	Registered Nurses	3,056	3,097	62,105	20.05	3
4	Licensed Practical Nurses	21,128	21,348	347,510	16.28	4
5	CNAs & Orderlies	62,413	63,756	570,560	8.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,879	1,955	20,370	10.42	9
10	Activity Assistants	1,894	1,977	17,342	8.77	10
11	Social Service Workers	2102	2,102	23,042	10.96	11
12	Dietician					12
13	Food Service Supervisor	1,992	1,992	24,086	12.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,248	11,505	90,812	7.89	15
16	Dishwashers					16
17	Maintenance Workers	2,088	2,088	34,679	16.61	17
18	Housekeepers	18,581	19,138	156,839	8.20	18
19	Laundry					19
20	Administrator	2,080	2,080	54,845	26.37	20
21	Assistant Administrator	1,080	1,080	16,197	15.00	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	32,422	15.59	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>	4,724	4,724	90,972	19.26	33
34	TOTAL (lines 1 - 33)	138,471	141,048	\$ 1,599,744 *	\$ 11.34	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	1,200	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)		\$ 10,200		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	9	303	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	\$ 303		53

Mt. Vernon Health Care Center
0047928
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,124	2,124	44,781	21.08
Marketing	520	520	8,750	16.83
Alzheimer's Coordinator	2,080	2,080	37,441	18.00
TOTAL (lines 1 - 35)	4,724	4,724	90,972	

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	\$ 54,845	Workers' Compensation Insurance	\$ 65,204	IDPH License Fee	\$ 995	
Lisa Dickey	Asst. Administrator	0	16,197	Unemployment Compensation Insurance	30,133	Advertising: Employee Recruitment	379	
				FICA Taxes	116,703	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	55,106	<u>Patient Background Checks</u>	<u>232</u> 2,320	
				Employee Meals		Miscellaneous Licenses & Permits	258	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		
				<u>Employee Relations</u>	<u>7,144</u>	IHCA Dues	1,500	
						Home Office Allocation	3,298	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,042			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ 211,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 211,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 274,290	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,750	
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
<u>Charter Communications</u>	<u>Computer Services</u>		\$ 779				Out-of-State Travel	\$
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		2,790					
<u>LTC Solutions</u>	<u>Computer Services</u>		1,700					
<u>Muzak LLC</u>	<u>Computer Services</u>		45	N/A			In-State Travel	
<u>SimpleLTC, Inc.</u>	<u>Computer Services</u>		81					
							Seminar Expense	
							<u>Home Office Allocation</u>	156
							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)	\$ 156

* Attach copy of IMRF notifications

**See instructions.

Mt. Vernon Health Care Center

0047928

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

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

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	44
GoffWilson, P.A.	Legal	62
Jackson Lewis	Legal	488
Peter Gartelos	Legal	47
Misc.	Legal	42
Ginoli & Company	Accountants	3,221
Miscellaneous Vendors	Computer Services	45
Emdeon Business Services	Computer Services	21
Advanced Answers on Demand	Computer Services	2,615
Access 2 Go	Computer Services	251
Ivans	Computer Services	156
Kemper Technology	Computer Services	711
VisionShare	Computer Services	221
MediFax	Computer Services	90
LogmeIn	Computer Services	39
Charter Communications	Computer Services	2
CDW	Computer Services	397
Simple LTC	Computer Services	603
Polaris Group	Other Professional Services	8,667
Donna Howard & Assoc.	Other Professional Services	148
Miscellaneous Vendors	Miscellaneous	415
Total (agree to Schedule V, line 19, column 8)		<u>23,680</u>

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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. 1,500 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. \$ 11,602 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. \$ 58,035
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. \$ 3,240
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.