

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	33	Skilled (SNF)	33	12,078	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,306	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,328	5,328	8
9	SNF/PED					9
10	ICF	16,188	6,629	515	23,332	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,188	6,629	5,843	28,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.05%

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

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 05/09/1990

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 32 and days of care provided 4,692

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Mount Vernon Cntryside Manor # 0035998 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	178,052	17,080	7,862	202,994		202,994		202,994		1
2	Food Purchase		130,458		130,458		130,458	(1,987)	128,471		2
3	Housekeeping	95,458	15,266		110,724		110,724	430	111,154		3
4	Laundry	74,786	8,412		83,198		83,198		83,198		4
5	Heat and Other Utilities			102,137	102,137		102,137	(6,097)	96,040		5
6	Maintenance	77,933	44,061	34,661	156,655		156,655	3,992	160,647		6
7	Other (specify):* Sanitation			6,083	6,083		6,083		6,083		7
8	TOTAL General Services	426,229	215,277	150,743	792,249		792,249	(3,662)	788,587		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	1,654,686	89,399	4,108	1,748,193		1,748,193		1,748,193		10
10a	Therapy										10a
11	Activities	43,032	2,117	1,535	46,684	94	46,778		46,778		11
12	Social Services	49,815		1,722	51,537	(94)	51,443		51,443		12
13	CNA Training										13
14	Program Transportation		10,126		10,126		10,126		10,126		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,747,533	101,642	13,865	1,863,040		1,863,040		1,863,040		16
	C. General Administration										
17	Administrative	71,612	9,066	210,000	290,678	(6,504)	284,174	(95,799)	188,375		17
18	Directors Fees										18
19	Professional Services			16,706	16,706	6,504	23,210	195	23,405		19
20	Dues, Fees, Subscriptions & Promotions			41,503	41,503		41,503	(30,757)	10,746		20
21	Clerical & General Office Expenses	35,041	11,733	55,361	102,135		102,135	98,694	200,829		21
22	Employee Benefits & Payroll Taxes			304,953	304,953		304,953	14,232	319,185		22
23	Inservice Training & Education			3,574	3,574	(981)	2,593		2,593		23
24	Travel and Seminar			2,391	2,391	981	3,372	153	3,525		24
25	Other Admin. Staff Transportation			1,554	1,554		1,554	466	2,020		25
26	Insurance-Prop.Liab.Malpractice			56,323	56,323		56,323	1,334	57,657		26
27	Other (specify):*										27
28	TOTAL General Administration	106,653	20,799	692,365	819,817		819,817	(11,482)	808,335		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,280,415	337,718	856,973	3,475,106		3,475,106	(15,144)	3,459,962		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

Mount Vernon Cntryside Manor

#0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			170,814	170,814		170,814	6,036	176,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12	12		12		12			32
33	Real Estate Taxes			146,863	146,863		146,863		146,863			33
34	Rent-Facility & Grounds							6,244	6,244			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			317,689	317,689		317,689	12,280	329,969			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,870	597,901	780,771		780,771		780,771			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,922	193,922		193,922		193,922			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		182,870	791,823	974,693		974,693		974,693			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,280,415	520,588	1,966,485	4,767,488		4,767,488	(2,864)	4,764,624			45

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

Mt. Vernon Countryside Manor, Inc.
Reclassifications
12/31/2016

Activities	Line 11	94
Social Services	Line 12	(94)

Reclass cost of activities consultant to correct line

Administrative	Line 17	(6,504)
Professional Services	Line 19	6,504

Reclass accounting fees to correct line

Inservice Training & Education	Line 23	(981)
Travel & Seminar	Line 24	981

Reclass seminar expenses to correct line

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	(842)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,262)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,145)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,200)	20		18
19	Entertainment	(302)	17		19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,859)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,035)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,438)	20		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(335)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,418)		\$	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)	41,554	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,554		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,864)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Mount Vernon Cntryside Manor

ID# 0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	To eliminate lobbying portion of IHCA dues	\$ (2,105)	20	1
2	To eliminate chamber of commerce dues	(220)	20	2
3	To add back 2016 IDPH License paid in 2015	1,990	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(335)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Cntryside Manor# 0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,987)	0	0	0	0	0	0	0	0	0	0	(1,987)	2
3	Housekeeping	0	430	0	0	0	0	0	0	0	0	0	430	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,262)	1,165	0	0	0	0	0	0	0	0	0	(6,097)	5
6	Maintenance	0	3,992	0	0	0	0	0	0	0	0	0	3,992	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,249)	5,587	0	(3,662)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(302)	(95,497)	0	0	0	0	0	0	0	0	0	(95,799)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,859)	4,054	0	0	0	0	0	0	0	0	0	195	19
20	Fees, Subscriptions & Promotions	(31,008)	251	0	0	0	0	0	0	0	0	0	(30,757)	20
21	Clerical & General Office Expenses	0	98,694	0	0	0	0	0	0	0	0	0	98,694	21
22	Employee Benefits & Payroll Taxes	0	14,232	0	0	0	0	0	0	0	0	0	14,232	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	153	0	0	0	0	0	0	0	0	0	153	24
25	Other Admin. Staff Transportation	0	466	0	0	0	0	0	0	0	0	0	466	25
26	Insurance-Prop.Liab.Malpractice	0	1,334	0	0	0	0	0	0	0	0	0	1,334	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(35,169)	23,687	0	(11,482)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,418)	29,274	0	(15,144)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Cntryside Manor# 0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	6,036	0	0	0	0	0	0	0	0	0	6,036	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,244	0	0	0	0	0	0	0	0	0	6,244	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	12,280	0	0	0	0	0	0	0	0	0	12,280	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(44,418)	41,554	0	0	0	0	0	0	0	0	0	(2,864)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Denise King 2012 Exempt Trust	20	Aviston Countryside Manor, Inc.	Aviston, IL	King Management Co.	O'Fallon, IL	Home Office
Leslie Pedtke 2012 Exempt Trust	20	Taylorville Care Center, Inc.	Taylorville, IL	Residential Living Ctr	Mt. Vernon, IL	Assisted Living
Keith King 2012 Exempt Trust	20			Taylorville Estates	Taylorville, IL	Assisted Living
Elizabeth Todorov 2012 Exempt Trust	20			Trenton Village	Trenton, IL	Asstd Liv/Mem Care
Michelle Hirschfield 2012 Exempt Trust	20					

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	3 See Schedule VIII	\$	King Management Company	0.00%	\$ 430	\$	430	1
2	V	5 See Schedule VIII		King Management Company	0.00%	1,165		1,165	2
3	V	6 See Schedule VIII		King Management Company	0.00%	3,992		3,992	3
4	V	17 See Schedule VIII	210,000	King Management Company	0.00%	114,503		(95,497)	4
5	V	19 See Schedule VIII		King Management Company	0.00%	4,054		4,054	5
6	V	20 See Schedule VIII		King Management Company	0.00%	251		251	6
7	V	21 See Schedule VIII		King Management Company	0.00%	98,694		98,694	7
8	V	22 See Schedule VIII		King Management Company	0.00%	14,232		14,232	8
9	V	24 See Schedule VIII		King Management Company	0.00%	153		153	9
10	V	25 See Schedule VIII		King Management Company	0.00%	466		466	10
11	V	26 See Schedule VIII		King Management Company	0.00%	1,334		1,334	11
12	V	30 See Schedule VIII		King Management Company	0.00%	6,036		6,036	12
13	V	34 See Schedule VIII		King Management Company	0.00%	6,244		6,244	13
14	Total		\$ 210,000			\$ 251,554	\$ *	41,554	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number Mount Vernon Cntryside Manor # 0035998 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Denise King	President	Administrative	20.00	185,362	14	35.00	Salary	\$ 114,401	17,8	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	\$ 114,401		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 Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

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 King Management Company
 Street Address 1670 Essex Way, Suite B
 City / State / Zip Code O'Fallon, IL 62269
 Phone Number (618) 327-3064
 Fax Number (618) 327-3083

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping	Accumulated Costs	13,397,043	6	\$ 1,264	\$ 4,557,488	\$ 430	1	
2	5	Utilities	Accumulated Costs	13,397,043	6	3,425	4,557,488	1,165	2	
3	6	Maintenance	Accumulated Costs	13,397,043	6	11,735	4,557,488	3,992	3	
4	17	Administrative	Accumulated Costs	13,397,043	6	336,590	336,291	4,557,488	114,503	4
5	19	Professional Services	Accumulated Costs	13,397,043	6	11,916	4,557,488	4,054	5	
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	13,397,043	6	739	4,557,488	251	6	
7	21	Clerical & Office Expense	Accumulated Costs	13,397,043	6	290,118	237,401	4,557,488	98,694	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	13,397,043	6	41,836	4,557,488	14,232	8	
9	24	Travel & Seminar	Accumulated Costs	13,397,043	6	450	4,557,488	153	9	
10	25	Other Administrative Transp.	Accumulated Costs	13,397,043	6	1,371	4,557,488	466	10	
11	26	Insurance	Accumulated Costs	13,397,043	6	3,922	4,557,488	1,334	11	
12	30	Depreciation	Accumulated Costs	13,397,043	6	17,743	4,557,488	6,036	12	
13	34	Rent-Facility & Grounds	Accumulated Costs	13,397,043	6	18,355	4,557,488	6,244	13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 739,464	\$ 573,692	\$ 251,554	25	

Facility Name & ID Number

Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Interest on Medicare Recoupments										12	6						
7												7						
8												8						
9	TOTAL Facility Related					\$	\$			\$	12	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related					\$	\$			\$		14						
15	TOTALS (line 9+line14)					\$	\$			\$	12	15						

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Cntryside Manor COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0035998

CONTACT PERSON REGARDING THIS REPORT Amy Elik

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-28-376-013</u>	<u>2S 3E LMC Plaza - Lots 1 thru 5</u>	\$ <u>235,310.84</u>	\$ <u>142,363.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>235,310.84</u></u>	\$ <u><u>142,363.06</u></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? X YES _____ NO

If YES, attach an explanation and 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

Residential Living Center is a 51 Unit, 36,000 square foot retirement center located on the property adjacent to Mt Vernon Countryside Manor.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Rows include Facility (1988, \$61,425) and a TOTALS row.

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	91		1990	1990	\$ 2,725,128	\$ 90,838	30	\$ 90,838		\$ 2,422,221	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Landscaping	1990		26,544		10			26,544	9
10		Parking Lot	1990		26,563		10			26,563	10
11		Door & Screen	1992		1,700		10			1,700	11
12		Vanity & Medicine Cabinet	1992		1,136		10			1,136	12
13		Garage	1993		7,238		15			7,238	13
14		Water Heater	1995		2,960		15			2,960	14
15		Smoke Detectors	1996		812		10			812	15
16		Air Conditioners	1996		1,342		5			1,342	16
17		Multiflow Furnace/Condensing Unit	1996		1,541		5			1,541	17
18		Storage Building Roof	1996		5,100		10			5,100	18
19		Asphalt East Parking Lot	1996		2,373		10			2,373	19
20		Air Conditioners	1996		1,549		5			1,549	20
21		Entry Control System	1996		1,133		10			1,133	21
22		Vinyl Floor Covering	1996		4,465		10			4,465	22
23		Fire Alarm System	1997		13,564		15			13,564	23
24		Furnace & Tempering Valve	1997		2,112		15			2,112	24
25		Air Conditioners (2)	1997		1,502		10			1,502	25
26		Water Heater	1998		3,273		15			3,273	26
27		Air Freshener System	1998		1,314		10			1,314	27
28		Air Freshener System	1998		1,300		10			1,300	28
29		Gazebo	1998		2,974		15			2,974	29
30		Water Heater	1999		3,414		15			3,414	30
31		Water Heater	1999		2,429		15			2,429	31
32		Carpet	2000		9,666		10			9,666	32
33		Flooring	2000		18,661		10			18,661	33
34		Concrete Pad for Gazebo	2000		4,303		15			4,303	34
35		Landscaping	2001		7,305		10			7,305	35
36		Electrical Repairs	2001		6,691		10			6,691	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

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	2001	\$ 2,745	\$	15	\$	\$	\$ 2,745	37
38	Cabinets	2001	28,181	1,409	20	1,409		22,310	38
39	Office Remodel	2002	5,319	354	15	354		5,112	39
40	Wall Brackets	2002	4,577		10			4,577	40
41	Shower Room Tile	2002	3,108		10			3,108	41
42	Air Conditioners (8)	2002	6,164		5			6,164	42
43	Air Conditioners (7)	2003	5,220		5			5,220	43
44	Telephone System	2003	9,538		10			9,538	44
45	Air Conditioners (5)	2003	4,684		5			4,684	45
46	Water Softener System	2003	6,199		12			6,199	46
47	HVAC Units (9)	2004	6,493		5			6,493	47
48	HVAC Units (3)	2004	2,164		5			2,164	48
49	HVAC Units (10)	2004	7,214		5			7,214	49
50	Wallcovering	2004	10,456		5			10,456	50
51	Doors & Kickplates	2004	5,262	351	15	351		4,473	51
52	Concrete Driveway	2004	4,257	284	15	284		3,500	52
53	Landscaping	2005	20,005		10			20,005	53
54	Lighting - 300 Hall Exit	2005	3,269		10			3,269	54
55	HVAC Units (3)	2005	2,417		5			2,417	55
56	Sprinkler Pipe Replacement	2006	36,670	1,467	25	1,467		15,401	56
57	Parking Lot Slab	2006	22,000	1,467	15	1,467		15,156	57
58	Window Treatments	2006	16,296	1,358	10	1,358		16,296	58
59	Painting & Wallpaper	2006	29,844		5			29,844	59
60	Flooring	2006	62,193	5,183	10	5,183		62,193	60
61	Heating & Cooling Units (7)	2006	3,731	249	10	249		3,731	61
62	Water Heater	2006	5,525	138	10	138		5,525	62
63	Water Heater	2006	5,153	43	10	43		5,153	63
64	Wallguards	2006	3,478		5			3,478	64
65	Light Fixtures	2006	1,278	106	10	106		1,278	65
66	Wallguards	2007	2,191	219	10	219		2,173	66
67	Nurse Station Flooring	2007	10,127	1,013	10	1,013		9,958	67
68	Custom Nurse Station	2007	17,030	1,419	12	1,419		13,955	68
69	Custom Cabinetry and Tops	2007	11,369	947	12	947		9,316	69
70	TOTAL (lines 4 thru 69)		\$ 3,252,249	\$ 106,845		\$ 106,845	\$	\$ 2,908,290	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,252,249	\$ 106,845		\$ 106,845	\$	\$ 2,908,290	1
2	New Roof	2007	90,380	9,038	10	9,038		88,120	2
3	Blinds	2007	2,019		5			2,019	3
4	Gutters	2007	6,500	650	10	650		6,283	4
5	Commercial Heater	2007	5,846	584	10	584		5,748	5
6	Iron Fence	2008	21,585	863	25	863		7,555	6
7	Lighted Fountain	2008	3,331	222	15	222		1,924	7
8	Doors	2010	1,506	100	15	100		628	8
9	Sprinkler System Heads (53)	2010	8,441	338	25	338		2,167	9
10	Satellite Dishes	2010	13,900	1,390	10	1,390		8,687	10
11	Interior Doors (161)	2010	94,717	6,314	15	6,314		38,413	11
12	Water Heaters (2)	2011	9,459	946	10	946		5,359	12
13	Air Conditioning System - 3-ton	2011	6,800	340	5	340		6,800	13
14	Water Softeners (2)	2011	4,345	434	10	434		2,317	14
15	Bridge Upgrade - Concrete	2011	10,718	714	15	714		3,871	15
16	Water Heaters (2)	2012	15,222	1,522	10	1,522		6,723	16
17	Air Conditioner - 5-ton	2012	4,850	485	10	485		2,182	17
18	Walk-In Cooler Condensing Unit	2012	2,638	176	15	176		777	18
19	PTAC Heating & Cooling Units (10)	2012	7,333	489	15	489		2,118	19
20	HVAC System w/2-ton Condensing Unit	2013	5,500	367	15	367		1,283	20
21	Water Heater	2013	7,236	724	10	724		2,171	21
22	Water Filtration Equipment	2014	4,358	436	10	436		944	22
23	4 Ton A/C Unit & Furnace	2015	3,407	227	15	227		341	23
24	Water Filtration System	2015	4,398	440	10	440		770	24
25	Service Entrance Door	2015	2,894	145	20	145		169	25
26	Natural Gas Water Heater	2015	19,626	1,963	10	1,963		3,481	26
27	Sprinkler System Replacement	2015	4,093	164	25	164		191	27
28	2-5 ton AC Units & Furnaces	2016	7,210	481	10	481		481	28
29	Wood Flooring	2016	5,624	47	10	47		47	29
30	Concrete Sidewalks	2016	5,000	139	15	139		139	30
31	Landscaping	2016	8,006	400	10	400		400	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,639,191	\$ 136,983		\$ 136,983	\$	\$ 3,110,398	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,639,191	\$ 136,983		\$ 136,983	\$	\$ 3,110,398	1
2									2
3									3
4	Home Office Additions:								4
5	Front Door-disposed in 2016	2002			10				5
6	Wallpaper-disposed in 2016	2007			10	13	13		6
7	Wallpaper-disposed in 2016	2008			5				7
8	Carpet-disposed in 2016	2008			5				8
9	Tile Flooring-disposed in 2016	2009			10	9	9		9
10	Wallpaper-disposed in 2016	2009			5				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	TOTAL (lines 1 thru 33)		\$ 3,639,191	\$ 136,983		\$ 137,005	\$ 22	\$ 3,110,398	34

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

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 234,079	\$ 31,440	\$ 33,264	\$ 1,824	3-15 Yrs	\$ 178,704	71
72	Current Year Purchases	67,610	2,391	3,872	1,481	3-15 Yrs	3,872	72
73	Fully Depreciated Assets	464,425					464,425	73
74								74
75	TOTALS	\$ 766,114	\$ 33,831	\$ 37,136	\$ 3,305		\$ 647,001	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2000 Chevy LS van w/ Lift	2001	\$ 22,659	\$	\$	\$	4	\$ 22,659	76
77	Facility	2003 Ford Supreme Shuttle Bus	2003	40,750				4	40,750	77
78	Facility	Utility Trailer	2004	1,867				4	1,867	78
79	Home Office Vehicle	2012 Acura	2012	10,837		2,709	2,709	4	10,837	79
80	TOTALS			\$ 76,113	\$	\$ 2,709	\$ 2,709		\$ 76,113	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)	\$ 4,542,843	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,814	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 176,850	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,036	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,833,512	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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 N/A NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES N/A NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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>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			
		1	2	3	4
		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
					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	39,2	# of prescrpts				182,474		182,474	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Therapy</u>	39,3				547,177			547,177	12	
13	Other (specify): <u>Labs,X-Ray,Ambul,Su</u>	39,3 & 39,2				50,724	396		51,120	13	
14	TOTAL			\$		\$ 597,901	\$ 182,870		\$ 780,771	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2016**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 492,366	\$	1
2	Cash-Patient Deposits	3,788		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>200,000</u>)	1,617,720		3
4	Supply Inventory (priced at <u>Cost</u>)	8,644		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,265		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	950		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,148,733	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	74,431		13
14	Buildings, at Historical Cost	3,619,046		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	789,546		16
17	Accumulated Depreciation (book methods)	(3,794,146)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 688,877	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,837,610	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 285,227	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,788		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,534		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,422		31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Provider Taxes</u>	25,415		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 643,386	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Shareholder</u>	725,314		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 725,314	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,368,700	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,468,910	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,837,610	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,136,264	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,136,264	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	892,146	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	(1,559,500)	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)	\$ (667,354)	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)	\$ 1,468,910	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,685,578	1
2	Discounts and Allowances for all Levels	(2,087,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,597,882	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,006,150	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,006,150	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	842	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	21,758	19
20	Radiology and X-Ray	25,106	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,706	23
D. Non-Operating Revenue			
24	Contributions	239	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 239	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,507	28
28a	Misc Rental Income	6,150	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,659,634	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	792,249	31
32	Health Care	1,863,040	32
33	General Administration	819,817	33
B. Capital Expense			
34	Ownership	317,689	34
C. Ancillary Expense			
35	Special Cost Centers	780,771	35
36	Provider Participation Fee	193,922	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,767,488	40
41	Income before Income Taxes (line 30 minus line 40)**	892,146	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 892,146	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,223,045	44
45	Private Pay - Net Inpatient Revenue	794,275	45
46	Medicare - Net Inpatient Revenue	580,562	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,597,882	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

MT. VERNON COUNTRYSIDE MANOR, INC.
Book to Tax Income Reconciliation
ATTACHMENT TO SCHEDULE XVII
12/31/2016

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 892,146
DEPRECIATION ADJUSTMENT	28,432
CONVERSION TO CASH BASIS ADJUSTMENTS	(126,751)
OTHER MISC BOOK TO TAX ADJUSTMENTS	24,864
TAX NET INCOME	<u>\$ 818,691</u>

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	1,808	2,117	\$ 62,602	\$ 29.57	1
2	Assistant Director of Nursing	1,657	1,915	41,977	21.92	2
3	Registered Nurses	14,854	15,407	346,925	22.52	3
4	Licensed Practical Nurses	13,323	14,210	261,185	18.38	4
5	CNAs & Orderlies	64,634	65,951	750,925	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,703	5,942	72,975	12.28	8
9	Activity Director	1,744	1,800	18,043	10.02	9
10	Activity Assistants	2,193	2,389	24,989	10.46	10
11	Social Service Workers	3,960	4,196	49,815	11.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,066	17,084	178,052	10.42	15
16	Dishwashers					16
17	Maintenance Workers	4,047	4,358	77,933	17.88	17
18	Housekeepers	10,121	10,479	95,458	9.11	18
19	Laundry	8,207	8,491	74,786	8.81	19
20	Administrator	1,867	2,094	71,612	34.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,001	2,462	35,041	14.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,822	1,952	21,300	10.91	31
32	Other Health C: <u>MDS/CarePlan</u>	3,907	4,285	96,797	22.59	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,914	165,132	\$ 2,280,415 *	\$ 13.81	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	132	\$ 7,139	1,3	35
36	Medical Director	Contract	6,500	9,3	36
37	Medical Records Consultant	20	1,300	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,808	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	23	1,629	11,3	44
45	Social Service Consultant	23	1,628	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 21,004		49

C. CONTRACT NURSES

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

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		
Tyger Downen	Administrator	0	\$ 71,612	Workers' Compensation Insurance	\$ 50,649	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	40,443	Advertising: Employee Recruitment	853		
				FICA Taxes	165,352	Health Care Worker Background Check (Indicate # of checks performed 175)	1,750		
				Employee Health Insurance	43,415	Fingerprinting	1,000		
				Employee Meals		IHCA Dues	3,355		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Licenses	1,547		
				Employee Physicals	817	Home Office Allocation	251		
				Employee Relations	2,525	Less: Public Relations Expense	()		
				Pension Expense-Employer Contribution	1,752	Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,612	Home Office Allocation	14,232	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,746	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Management Fee - King Management Company			\$ 210,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 210,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount		Line #	Amount		Amount	
C.J. Schlosser & Company	Accounting		\$ 12,666	Section N/A		\$	Out-of-State Travel	\$	
Mathis, Marifian & Richter	Collections - Eliminated		3,859				In-State Travel		
Greensfelder, Hemker & Gale	Employee Handbook revisions		181				Seminar Expense	3,372	
							Home Office Allocation	153	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 16,706	TOTAL			\$	TOTAL	\$ 3,525

* Attach copy of IMRF notifications

**See instructions.

MT. VERNON COUNTRYSIDE MANOR, INC.
 Legal Fees
 ATTACHMENT TO SCHEDULE XIX-C
 12/31/2016

<u>Invoice Date</u>	<u>Law Firm Name</u>	<u>Allowable/No n-allowable</u>	<u>Amount</u>	<u>Description</u>
1/28/2016	Greensfelder, Hemker & Gale	Allowable	181.25	Employee handbook revisions
3/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	208.00	Patient account collections
7/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	460.00	Patient account collections
8/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	200.00	Patient account collections
9/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	600.67	Patient account collections
10/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	200.00	Patient account collections
11/30/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	340.00	Patient account collections
12/31/2016	Mathis, Marifian & Richter, Ltd	Non-allowable	2,050.00	Patient account collections
Recoupment of legal fees on patient account		Non-allowable	(200.00)	
			4,039.92	

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA Dues \$3,355
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 193,922
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 842
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees