

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0035998</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Mt. Vernon Countryside Manor, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>606 New Fairfield Road</u> <u>Mt. Vernon</u> <u>62864</u>			
NumberCityZip Code			
County: <u>Jefferson</u>			
Telephone Number: <u>(618) 242-1800</u> Fax # <u>(618) 242-1878</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>05/09/1990</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc.

0035998 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,045</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,820</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,237</u>	<u>363</u>	<u>6,251</u>	<u>7,851</u>	8
9	SNF/PED					9
10	ICF	<u>16,518</u>	<u>4,962</u>		<u>21,480</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,755</u>	<u>5,325</u>	<u>6,251</u>	<u>29,331</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.56%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 05/09/1990

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 32 and days of care provided 6,251

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc. # 0035998 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	175,052	9,086	8,092	192,230		192,230		192,230			1
2	Food Purchase		134,350		134,350		134,350	(1,380)	132,970			2
3	Housekeeping	68,898	17,852		86,750		86,750	802	87,552			3
4	Laundry	108,398	12,065		120,463		120,463		120,463			4
5	Heat and Other Utilities			92,418	92,418		92,418	(6,674)	85,744			5
6	Maintenance	70,426	79,403	1,020	150,849	135	150,984	48,735	199,719			6
7	Other (specify):* Sanitation			6,910	6,910		6,910		6,910			7
8	TOTAL General Services	422,774	252,756	108,440	783,970	135	784,105	41,483	825,588			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,626,503	102,787	3,951	1,733,241		1,733,241		1,733,241			10
10a	Therapy			321	321		321		321			10a
11	Activities	38,731	1,998	1,554	42,283		42,283		42,283			11
12	Social Services	57,618			57,618		57,618		57,618			12
13	CNA Training											13
14	Program Transportation		9,278		9,278		9,278		9,278			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,722,852	114,063	11,826	1,848,741		1,848,741		1,848,741			16
	C. General Administration											
17	Administrative	65,660	13,364	838,831	917,855	(3,482)	914,373	(589,365)	325,008			17
18	Directors Fees											18
19	Professional Services			19,440	19,440		19,440	4,792	24,232			19
20	Dues, Fees, Subscriptions & Promotions			12,645	12,645	3,018	15,663	(6,328)	9,335			20
21	Clerical & General Office Expenses	25,816	19,163	97,894	142,873	329	143,202	67,788	210,990			21
22	Employee Benefits & Payroll Taxes			330,234	330,234		330,234	22,715	352,949			22
23	Inservice Training & Education			535	535		535	(119)	416			23
24	Travel and Seminar			6,487	6,487		6,487	(706)	5,781			24
25	Other Admin. Staff Transportation							6,674	6,674			25
26	Insurance-Prop.Liab.Malpractice			43,683	43,683		43,683	1,524	45,207			26
27	Other (specify):*											27
28	TOTAL General Administration	91,476	32,527	1,349,749	1,473,752	(135)	1,473,617	(493,025)	980,592			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,237,102	399,346	1,470,015	4,106,463		4,106,463	(451,542)	3,654,921			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			168,316	168,316		168,316	12,891	181,207			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			128,818	128,818		128,818	1,088	129,906			33
34	Rent-Facility & Grounds			5,500	5,500		5,500	(5,500)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			302,634	302,634		302,634	8,479	311,113			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		202,819	752,349	955,168		955,168		955,168			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298		55,298		55,298			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		202,819	807,647	1,010,466		1,010,466		1,010,466			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,237,102	602,165	2,580,296	5,419,563		5,419,563	(443,063)	4,976,500			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(471)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,728)	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	(909)	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	(682)	17		18
19	Entertainment	(6,512)	17		19
20	Contributions	(700)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,748)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,244)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(693)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,655)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,342)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 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)	(414,721)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (414,721)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (443,063)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning:

ID#0035998

Ending:

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Lobbying Portion of 2011 IHCA Dues	\$ (1,873)	20	1
2	Straight Line Depr. On Items Req'd To Be Capitalized	(105)	30	2
3	Eliminate Out-of-State Travel	(119)	23	3
4	Offset Miscellaneous Reimbursements & Refunds	(508)	17	4
5	Eliminate Non Employee Travel	(1,050)	24	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,655)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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
Jerry & Marilyn King	100.00	Aviston Countryside Manor, Inc.	Aviston	King Management	Nashville	Home Office
				King Management	Bonita Springs, FL	Management Co.
		Taylorville Care Center, Inc.	Taylorville	of SW Florida		
				Residential Living Ctr.	Mt. Vernon	Assisted Living
				Taylorville Estates	Taylorville	Assisted Living
				Trenton Village	Trenton	Assisted Living

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	See Schedule VIII	\$	King Management Co.	100.00%	\$ 802	\$ 802	1
2	V	5	See Schedule VIII		King Management Co.	100.00%	1,054	1,054	2
3	V	6	See Schedule VIII		King Management Co.	100.00%	48,735	48,735	3
4	V	17	See Schedule VIII		King Management Co.	100.00%	108,844	108,844	4
5	V	19	See Schedule VIII		King Management Co.	100.00%	6,043	6,043	5
6	V	20	See Schedule VIII		King Management Co.	100.00%	1,110	1,110	6
7	V	21	See Schedule VIII		King Management Co.	100.00%	68,481	68,481	7
8	V	22	See Schedule VIII		King Management Co.	100.00%	18,028	18,028	8
9	V	25	See Schedule VIII		King Management Co.	100.00%	6,674	6,674	9
10	V	26	See Schedule VIII		King Management Co.	100.00%	1,524	1,524	10
11	V	30	See Schedule VIII		King Management Co.	100.00%	12,996	12,996	11
12	V	33	See Schedule VIII		King Management Co.	100.00%	1,088	1,088	12
13	V								13
14	Total			\$			\$ 275,379	\$ * 275,379	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		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	34	Land Lease	\$ 5,500	Jerry & Marilyn King		\$	\$ (5,500)	15
16	V								16
17	V	17	See Schedule VIII	838,831	King Management of SW Florida	100.00%	148,324	(690,507)	17
18	V	19	See Schedule VIII		King Management of SW Florida	100.00%	497	497	18
19	V	20	See Schedule VIII		King Management of SW Florida	100.00%	379	379	19
20	V	22	See Schedule VIII		King Management of SW Florida	100.00%	4,687	4,687	20
21	V	24	See Schedule VIII		King Management of SW Florida	100.00%	344	344	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			\$ 844,331			\$ 154,231	\$ * (690,100)	39

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc. # 0035998 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00	258,714	16	32.57	Salary	\$ 146,370	17, 8	1
2	Denise King	Regional Director	Administrative	0.00	190,994	20	32.57	Salary	108,057	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	78,631	16	32.57	Salary	44,486	6, 8	3
4	Marilyn King	Owner	Mgmt/Consultant	100.00	3,455	1	32.57	Salary	1,954	17, 8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 300,867		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc. # 0035998 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 935 Mill Street
City / State / Zip Code Nashville, IL 62263
Phone Number (618) 327-3064
Fax Number (618) 327-3083

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping	Accumulated Costs	14,062,392	6	\$ 2,462	\$	4,580,733	\$ 802	1
2	5	Utilities	Accumulated Costs	14,062,392	6	3,237		4,580,733	1,054	2
3	6	Maintenance	Accumulated Costs	14,062,392	6	149,612	136,568	4,580,733	48,735	3
4	17	Administrative	Accumulated Costs	14,062,392	6	334,141	331,724	4,580,733	108,844	4
5	19	Professional Fees	Accumulated Costs	14,062,392	6	18,550		4,580,733	6,043	5
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	14,062,392	6	3,408		4,580,733	1,110	6
7	21	Clerical & Office Expense	Accumulated Costs	14,062,392	6	210,230	160,883	4,580,733	68,481	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	14,062,392	6	55,345		4,580,733	18,028	8
9	25	Other Administrative Transp.	Accumulated Costs	14,062,392	6	20,487		4,580,733	6,674	9
10	26	Insurance	Accumulated Costs	14,062,392	6	4,678		4,580,733	1,524	10
11	30	Depreciation - Other	Accumulated Costs	14,062,392	6	17,432		4,580,733	5,678	11
12	30	Depreciation - Vehicles	Accumulated Costs	14,062,392	6	22,466		4,580,733	7,318	12
13	33	Real Estate Taxes	Accumulated Costs	14,062,392	6	3,339		4,580,733	1,088	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					\$ 845,387	\$ 629,175		\$ 275,379	25

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc. # 0035998 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 of SW Florida
Street Address 3440 Riviera Lakes Ct.
City / State / Zip Code Bonita Springs, FL 34134
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Administrative	Accumulated Costs	14,062,392	6	\$ 455,340	\$ 455,340	4,580,733	\$ 148,324	1
2	19	Professional Fees	Accumulated Costs	14,062,392	6	1,525		4,580,733	497	2
3	20	Dues, Fees & Subscriptions	Accumulated Costs	14,062,392	6	1,165		4,580,733	379	3
4	22	Payroll Taxes	Accumulated Costs	14,062,392	6	14,388		4,580,733	4,687	4
5	24	Travel & Seminar	Accumulated Costs	14,062,392	6	1,055		4,580,733	344	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	TOTALS					\$ 473,473	\$ 455,340		\$ 154,231	25

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	
	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	Schedule Not Applicable						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$135,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$131,118	2
3. Under or (over) accrual (line 2 minus line 1).			\$(4,182)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$133,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$128,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2006	91,875	8
2007	93,882	9
2008	107,793	10
2009	131,510	11
2010	131,118	12

Line 4: Accrual is based on 2010 taxes paid.

Line 7: Real Estate Tax Expense \$128,818

Home Office Allocation 1,088

Total Real Estate Tax \$129,906

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Mt. Vernon Countryside Manor, Inc.</u>	COUNTY	<u>Jefferson</u>
FACILITY IDPH LICENSE NUMBER	<u>0035998</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Linda Peppenhorst</u>		
TELEPHONE	<u>(618) 327-3064</u>	FAX #:	<u>(618) 327-3083</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

38,000

B. General Construction Type:

Exterior Brick

Frame

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).

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/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.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 95,254	1
2	Home Office		1989 & 1995	2,049	2
3	TOTALS			\$ 97,303	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc.

0035998

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	101		1990	1990	\$ 2,725,128	\$ 90,838	30	\$ 90,838	\$	\$ 1,968,033
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		1990		26,544		10			26,544
10	Parking Lot		1990		26,563		10			26,563
11	Door & Screen		1992		1,700		10			1,700
12	Vanity & Medicine Cabinet		1992		1,136		10			1,136
13	Garage		1993		7,238		15			7,238
14	Water Heater		1995		2,960		15			2,960
15	Smoke Detectors		1996		812		10			812
16	Air Conditioners (2)		1996		1,342		5			1,342
17	Multiflow Furnace/Condensing Unit		1996		1,541		5			1,541
18	Storage Building Rook		1996		5,100		10			5,100
19	Asphalt East Parking Lot		1996		2,373		10			2,373
20	Air Conditioners (2)		1996		1,549		5			1,549
21	Entry Control System		1996		1,133		10			1,133
22	Vinyl Floor Covering		1996		4,465		10			4,465
23	Fire Alarm System		1997		13,564	904	15	904		13,338
24	Furnance & Tempering Valve		1997		2,112	141	15	141		2,089
25	Air Conditioners (2)		1997		1,502		10			1,502
26	Water Heater		1998		3,273	218	15	218		3,054
27	Air Freshner System		1998		1,314		10			1,314
28	Air Freshner System		1998		1,300		10			1,300
29	Gazebo		1998		2,974	198	15	198		2,677
30	Water Heater		1999		3,414	228	15	228		2,864
31	Water Heater		1999		2,429	162	15	162		2,038
32	Carpet		2000		9,666		10			9,666
33	Flooring		2000		18,661		10			18,661
34	Concrete Pad for Gazebo		2000		4,303		15	287	287	3,323
35	Landscaping		2001		7,305	365	10	365		7,305
36	Electrical Repairs		2001		6,691	112	10	112		6,691

*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

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc.

0035998

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Water Heater	2001	\$ 2,745	\$ 183	15	\$ 183	\$	\$ 2,013	37
38 Cabinets	2001	28,181	1,409	20	1,409		15,265	38
39 Office Remodel	2002	5,319	355	15	355		3,339	39
40 Wall Brackets	2002	4,577	458	10	458		4,462	40
41 Shower Room Tile	2002	3,108	311	10	311		2,849	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	954	10	954		7,948	44
45 Air Conditioners (5)	2003	4,683		5			4,683	45
46 Water Softener System	2003	6,199	517	12	517		4,606	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		2,719	51
52 Concrete Driveway	2004	4,257	284	15	284		2,081	52
53 Landscaping	2005	20,005	2,000	10	2,000		12,337	53
54 Lighting - 300 Hall Exit	2005	3,269	327	10	327		2,152	54
55 HVAC Units (3)	2005	2,417		5			2,417	55
56 Sprinkler Pipe Replacement	2006	36,670	1,467	25	1,467		8,068	56
57 Parking Lot Slab	2006	22,000	1,467	15	1,467		7,822	57
58 Window Treatment	2006	16,296	1,630	10	1,630		8,420	58
59 Painting & Wallpapering	2006	29,844	4,974	5	4,974		29,844	59
60 Flooring	2006	62,193	6,219	10	6,219		32,133	60
61 Heating & Cooling Units (7)	2006	3,731	373	10	373		1,990	61
62 Water Heater	2006	5,525	552	10	552		3,177	62
63 Water Heater	2006	5,153	515	10	515		3,049	63
64 Wallguards	2006	3,478	638	5	638		3,478	64
65 Light Fixtures	2006	1,278	128	10	128		660	65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,211,531	\$ 118,278		\$ 118,565	\$ 287	\$ 2,331,534	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Mt. Vernon Countryside Manor, Inc.

0035998

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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		\$ 3,211,531	\$ 118,278		\$ 118,565	\$ 287	\$ 2,331,534	1
2									2
3	Wallguard	2007	2,191	219	10	219		1,077	3
4	Nurse Station Flooring	2007	10,127	1,013	10	1,013		4,895	4
5	Custom Nurse Station	2007	17,030	1,419	12	1,419		6,859	5
6	Custom Cabinetry and Tops	2007	11,369	947	12	947		4,579	6
7	New Roof	2007	90,380	9,038	10	9,038		42,931	7
8	Blinds	2007	2,019	404	5	404		1,918	8
9	Gutters	2007	6,500	650	10	650		3,033	9
10	Commercial Heater	2007	5,846	585	10	585		2,825	10
11	Iron Fence	2008	21,585	863	25	863		3,238	11
12	Lighted Foundation	2008	3,331	222	15	222		814	12
13	Doors	2010	1,506	100	15	100		126	13
14	Sprinkler System Heads (53)	2010	8,441	338	25	338		478	14
15	Satellite Dishes	2010	13,900	1,390	10	1,390		1,738	15
16	Interior Doors (161)	2010	94,717	6,314	15	6,314		6,841	16
17	Water Heaters (2)	2011	9,459	629	10	629		629	17
18	Air Conditioning System - 3-ton	2011	6,800	1,020	5	1,020		1,020	18
19	Water Softeners (2)	2011	4,345	145	10	145		145	19
20	Bridge Upgrade - Concrete	2011	10,718	298	15	298		298	20
21									21
22	Home Office Parking Lot	1989	644		5			644	22
23	Home Office New Building	1995	31,932		25	1,277	1,277	20,650	23
24	Home Office Interior Finishes	1996	1,981		15	66	66	1,981	24
25	Home Office Carpet	1996	693		5			693	25
26	Home Office Cabinets	1996	1,096		20	55	55	849	26
27	Home Office Electrical	1996	379		15	13	13	379	27
28	Home Office Front Door	2002	521		10	52	52	482	28
29	Home Office Wallpaper	2007	298		5	30	30	124	29
30	Home Office Wallpaper	2008	2,444		5	489	489	1,955	30
31	Home Office Carpet	2008	3,011		5	602	602	2,409	31
32	Home Office Tile Flooring	2009	209		10	21	21	63	32
33	Home Office Wallpaper	2009	467		5	93	93	280	33
34	TOTAL (lines 1 thru 33)		\$ 3,575,470	\$ 143,872		\$ 146,857	\$ 2,985	\$ 2,445,487	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$213,768	\$22,897	\$25,417	\$2,520	3-15 years	\$113,201	71
72	Current Year Purchases	54,615	1,445	1,513	68	3-10 years	1,513	72
73	Fully Depreciated Assets	539,783					539,783	73
74								74
75	TOTALS	\$808,166	\$24,342	\$26,930	\$2,588		\$654,497	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	\$102	\$102		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 Vehicles	Various	Various	39,398		7,318	7,318	4	11,818	79
80	TOTALS			\$104,674	\$102	\$7,420	\$7,318		\$77,094	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,585,613	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$168,316	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$181,207	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12,891	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,177,078	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	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? ☒ N/A YES ☐ 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	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	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	39, 3	hrs	\$	13,659	\$ 249,950	\$	13,659	\$ 249,950	1
2	Licensed Speech and Language Development Therapist	39, 3	hrs		5,188	191,212		5,188	191,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39, 3	hrs		13,809	254,478		13,809	254,478	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				202,819		202,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39, 3				56,709			56,709	13
14	TOTAL			\$	32,656	\$ 752,349	\$ 202,819	32,656	\$ 955,168	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 389,596	\$	1
2	Cash-Patient Deposits	1,049		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	1,181,471		3
4	Supply Inventory (priced at Cost)	8,955		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,699		6
7	Other Prepaid Expenses	5,244		7
8	Accounts Receivable (owners or related parties)	1,397		8
9	Other(specify): See Attached	23,355		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,633,766	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,524,657		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	818,401		16
17	Accumulated Depreciation (book methods)	(3,089,528)		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)	\$ 1,253,530	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,887,296	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 375,952	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,049		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,418		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,668		31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due To Management Compnay</u>	238,831		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 942,918	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 942,918	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,944,378	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,887,296	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,981,680	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,981,680	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	634,192	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	(671,494)	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)	\$ (37,302)	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)	\$ 1,944,378	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Mt. Vernon Countryside Manor, Inc.**# **0035998**Report Period Beginning: **01/01/2011**Ending: **12/31/2011**

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,468,100	1
2	Discounts and Allowances for all Levels	(506,540)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,961,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,024,571	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,024,571	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	400	13
14	Non-Patient Meals	471	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	58,519	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,390	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,509	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,509	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	508	28
28a	<u>Vending Machine Income</u>	1,217	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,725	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,053,755	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	783,970	31
32	Health Care	1,848,741	32
33	General Administration	1,473,752	33
	B. Capital Expense		
34	Ownership	302,634	34
	C. Ancillary Expense		
35	Special Cost Centers	955,168	35
36	Provider Participation Fee	55,298	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,419,563	40
41	Income before Income Taxes (line 30 minus line 40)**	634,192	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 634,192	43

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

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

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

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

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	1,829	2,078	\$ 55,830	\$ 26.87	1
2	Assistant Director of Nursing	2,009	2,266	46,225	20.40	2
3	Registered Nurses	19,839	21,344	424,309	19.88	3
4	Licensed Practical Nurses	12,788	13,800	232,724	16.86	4
5	CNAs & Orderlies	83,514	84,299	846,567	10.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,615	4,009	38,731	9.66	10
11	Social Service Workers	4,381	4,777	57,618	12.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,290	17,656	175,052	9.91	15
16	Dishwashers					16
17	Maintenance Workers	4,033	4,561	70,426	15.44	17
18	Housekeepers	7,255	7,982	68,898	8.63	18
19	Laundry	11,943	12,605	108,398	8.60	19
20	Administrator	1,829	2,118	65,660	31.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,953	2,220	25,816	11.63	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	1,611	1,917	20,848	10.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,889	181,632	\$ 2,237,102 *	\$ 12.32	34

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	145	\$ 7,461	1, 3	35
36	Medical Director	Contract	6,000	9, 3	36
37	Medical Records Consultant	17	1,005	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,946	10, 3	39
40	Physical Therapy Consultant	Contract	240	10a, 3	40
41	Occupational Therapy Consultant	Contract	81	10a, 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,554	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	\$ 19,287		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$3,424
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

3-10 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

N/A
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 55,298

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

None
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 471
- (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?

62%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

MOUNT VERNON COUNTRYSIDE MANOR
IDPH# 0035998
RECLASSIFICATION
ATTACHMENT TO SCHEDULE V
12/31/2011

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	3,018
CLERICAL & GENERAL OFFICE	21	329
MAINTENANCE	6	135
ADMINISTRATIVE	17	(3,482)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
LICENSES & FEES	\$ 538	
TELEPHONE CHARGES	329	
BACKGROUND CHECKS	2,480	
MAINTENANCE SUPPLIES	135	
TOTAL	\$ <u>3,482</u>	

MT. VERNON COUNTRYSIDE MANOR
IDPH ID #0035998
ATTACHMENT TO SCHEDULE XVII
12/31/11

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 634,192
DEPRECIATION ADJUSTMENT	(22,638)
TRAVEL & ENTERTAINMENT ADJUSTMENT	3,256
ILLINOIS REPLACEMENT TAXES	693
CONVERSION TO CASH BASIS ADJUSTMENTS	(568,869)
TAX NET INCOME	<u>\$ 46,634</u>

MT. VERNON COUNTRYSIDE MANOR
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2011

NAME OF EMPLOYEE ATTENDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST	TRAVEL/ LODGING COST
Rhonda Moffitt	Activities	03/30/11	Carlyle	Achieving Excellence in Activity	Outcome Services of IL	70	
Tara Dehart	Activities	03/30/11	Carlyle	Achieving Excellence in Activity	Outcome Services of IL	70	
Various Staff	Various	03/29/11 - 03/30/11	Web Seminar	Master Interviews & Care Area Assessments	Polaris Group	318	
Marla Howard	Administrator	08/08/11	St. Louis	Compliance, Reimbursement, & Trending Medicare	Polaris Group	99	
Keisha Smith	MDS Coordinator	08/08/11	St. Louis	Compliance, Reimbursement, & Trending Medicare	Polaris Group	99	
Sophie Rudd	Care Plan Coordinator	08/08/11	St. Louis	Compliance, Reimbursement, & Trending Medicare	Polaris Group	99	
Marla Howard	Administrator	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	143	182
Jeanette Mostyn	Director of Nursing	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	143	182
Keisha Smith	MDS Coordinator	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	143	182
Sophie Rudd	Care Plan Coordinator	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	142	182
Dana Fults	Dietary	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	142	182
Denise King	Vice President of Operations	09/12/11 - 09/15/11	Peoria	IHCA Convention	IHCA	142	182
Erin Wallace	Social Services	10/04/11 - 10/05/11	Springfield	Leading The Way to Person-Centered Living in LTC	IL Pioneer Coalition	159	181
Tyger Downen	Social Services	10/04/11 - 10/05/11	Springfield	Leading The Way to Person-Centered Living in LTC	IL Pioneer Coalition	159	181
Beth Donoho	R.N. - Restorative Nurse	10/04/11 - 10/05/11	Springfield	Leading The Way to Person-Centered Living in LTC	IL Pioneer Coalition	159	181
Lacey Moffitt	Assistant Director of Nursing	10/04/11 - 10/05/11	Springfield	Leading The Way to Person-Centered Living in LTC	IL Pioneer Coalition	159	181
Marla Howard	Administrator	11/01/11 - 11/02/11	Springfield	INHAA Convention	INHAA	125	
Linda Peppenhorst	Operations Manager	2/25 - 3/1/12	Cruise	IHCA Cruise for Education	IHCA	1,250	
						3,621	1,816

MT. VERNON COUNTRYSIDE MANOR
IDPH #0035998
ATTACHMENT TO SCHEDULE XV, LINE 9
12/31/11

OTHER ASSETS:

INVESTMENT IN LTC INSURANCE	\$ 20,705
UTILITY DEPOSIT	250
SHORT-TERM NOTE RECEIVABLE - EMPLOYEE	<u>2,400</u>
	<u>\$ 23,355</u>

Mt. Vernon Countryside Manor
IDPH ID # 0035998
Attachment To Schedule VII C
Compensation Paid By Other Nursing Homes
12/31/11

<u>Name</u>	<u>Aviston Countryside Manor</u>	<u>Taylorville Care Center</u>	<u>Total Schedule VII C Column 5</u>
Jerry King	\$ 139,746	\$ 118,968	\$ 258,714
Denise King	103,167	87,827	190,994
Keith King	42,473	36,158	78,631
Marilyn King	1,866	1,589	3,455
Total	<u>\$ 287,252</u>	<u>\$ 244,542</u>	<u>\$ 531,794</u>