

		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: 0047928

Facility Name: Mt. Vernon Health Care Center

Address: 5 Doctors Park Mount Vernon 62864
Number City Zip Code

County: Jefferson

Telephone Number: (618) 242-1064 Fax # (618) 242-7559

HFS ID Number:

Date of Initial License for Current Owners: 3/01/2006

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☒	Corporation	☐	Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 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.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Mark B. Petersen	
Paid Preparer	(Title)	Chief Executive Officer	
	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone) () Fax # ()		
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

#	0047928	Report Period Beginning:	1/1/2011	Ending:	12/31/2011
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D. How many bed-hold days during this year were paid by the Department?

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

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

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES ☐ NO ☒

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

Date started 3/1/2006

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

YES ☒ Date 3/1/2006 NO ☐

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

YES ☐ NO ☒ If YES, enter number
of beds certified and days of care provided

Medicare Intermediary N/A

MODIFIED

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

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

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

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	61.23%
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Facility Name & ID Number Mt. Vernon Health Care Center # 0047928 Report Period Beginning: 1/1/2011 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	104,624	10,828		115,452		115,452	4,779	120,231			1
2	Food Purchase		132,921		132,921		132,921	(3,346)	129,575			2
3	Housekeeping	141,565	24,032		165,597		165,597	31	165,628			3
4	Laundry		8,791		8,791		8,791		8,791			4
5	Heat and Other Utilities			72,628	72,628		72,628	313	72,941			5
6	Maintenance	41,914	6,270	10,251	58,435		58,435	3,579	62,014			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,090	1,090			7
8	TOTAL General Services	288,103	182,842	82,879	553,824		553,824	6,446	560,270			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,106,257	56,912	4,352	1,167,521		1,167,521	48	1,167,569			10
10a	Therapy		15		15		15		15			10a
11	Activities	37,818	64	31	37,913		37,913	(5,283)	32,630			11
12	Social Services	27,774			27,774		27,774		27,774			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	1,171,849	56,991	13,383	1,242,223		1,242,223	(5,235)	1,236,988			16
	C. General Administration											
17	Administrative	19,846		132,000	151,846		151,846	(74,655)	77,191			17
18	Directors Fees											18
19	Professional Services			16,497	16,497		16,497	8,961	25,458			19
20	Dues, Fees, Subscriptions & Promotions			4,624	4,624		4,624	639	5,263			20
21	Clerical & General Office Expenses	30,108	3,466	10,966	44,540		44,540	51,060	95,600			21
22	Employee Benefits & Payroll Taxes			185,652	185,652		185,652		185,652			22
23	Inservice Training & Education							159	159			23
24	Travel and Seminar							47	47			24
25	Other Admin. Staff Transportation			3,935	3,935		3,935	8,462	12,397			25
26	Insurance-Prop.Liab.Malpractice			34,911	34,911		34,911	1,108	36,019			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							18,109	18,109			27
28	TOTAL General Administration	49,954	3,466	388,585	442,005		442,005	13,890	455,895			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,509,906	243,299	484,847	2,238,052		2,238,052	15,101	2,253,153			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.

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			92,211	92,211		92,211	(1,374)	90,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,158	61,158		61,158	42,897	104,055			32
33	Real Estate Taxes			18,865	18,865		18,865	394	19,259			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,107	21,107		21,107	701	21,808			35
36	Other (specify):*											36
37	TOTAL Ownership			193,341	193,341		193,341	42,618	235,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,072		1,072		1,072		1,072			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* Non-allowable Costs		621	2,503	3,124		3,124	(3,124)				43
44	TOTAL Special Cost Centers		1,693	60,538	62,231		62,231	(3,124)	59,107			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,509,906	244,992	738,726	2,493,624		2,493,624	54,595	2,548,219			45

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

VI. ADJUSTMENT DETAIL

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

	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	(3,368)	2		4
5	Telephone, TV & Radio in Resident Rooms	(786)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,723)	30		9
10	Interest and Other Investment Income	(4,578)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(242)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(782)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,362	43		24
25	Fund Raising, Advertising and Promotional	(3,679)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(5,917)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,713)		\$	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)	96,308	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 96,308		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 54,595		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

ID#0047928

Report Period Beginning:1/1/2011

Ending:12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	\$ (637)	21	1
2	Disallowed Special Events	3	43	2
3	Offset Transporation Revenue	(5,283)	11	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
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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	(5,917)		49

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
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,779	\$ 4,779	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	22	22	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	313	313	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,949	1,949	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,090	1,090	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	48	48	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	132,000	Petersen Health Care, Inc.	100.00%	57,345	(74,655)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,468	5,468	12
13	V								13
14	Total			\$ 132,000			\$ 71,045	\$ * (60,955)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 384	\$ 384	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	44,553	44,553	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	159	159	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	47	47	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,094	4,094	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,108	1,108	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	18,109	18,109	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,401	6,401	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,705	7,705	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	394	394	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	698	698	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			\$			\$ 83,652	\$ * 83,652	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	1,630	1,630	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12	Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	3,493	3,493	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	255	255	26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	7,144	7,144	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	4,368	4,368	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	16,948	16,948	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	39,770	39,770	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	3	3	38
39	Total			\$			\$ 73,611	\$ * 73,611	39

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

Facility Name & ID Number

Mt. Vernon Health Care Center

0047928

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

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

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				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

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			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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											1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Mt. Vernon Health Care Center # 0047928 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,542,131	77	\$ 311,109	\$ 308,619	23,690	\$ 4,779	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	23,690	22	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	23,690	31	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	23,690	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	23,690	313	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	23,690	1,949	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	23,690	1,090	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	23,690	48	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	23,690	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	23,690	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	23,690	57,345	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	23,690	5,468	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	23,690	384	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	23,690	44,553	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	23,690	159	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	23,690	47	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	23,690	4,094	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	23,690	1,108	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	23,690	18,109	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	23,690	6,401	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	23,690	7,705	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	23,690	394	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	23,690	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	23,690	698	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 154,697	25

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

Report Period Beginning:

1/1/2011Ending: 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

Petersen Health Care II, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	325,902	13	\$	\$	23,690	\$	1
2	2	Food	Resident Days	325,902	13			23,690		2
3	3	Housekeeping	Resident Days	325,902	13			23,690		3
4	4	Laundry	Resident Days	325,902	13			23,690		4
5	5	Utilities	Resident Days	325,902	13			23,690		5
6	6	Maintenance	Resident Days	325,902	13	22,420		23,690	1,630	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			23,690		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			23,690		8
9	10A	Therapy	Resident Days	325,902	13			23,690		9
10	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			23,690		10
11	17	Administrative	Resident Days	325,902	13			23,690		11
12	19	Professional Services	Resident Days	325,902	13	48,058		23,690	3,493	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		23,690	255	13
14	21	Clerical and General Office	Resident Days	325,902	13	98,273		23,690	7,144	14
15	23	Inservice Training & Education	Resident Days	325,902	13			23,690		15
16	24	Travel and Seminar	Resident Days	325,902	13			23,690		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		23,690	4,368	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			23,690		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			23,690		19
20	30	Depreciation	Resident Days	325,902	13	233,155		23,690	16,948	20
21	32	Interest	Resident Days	325,902	13	547,113		23,690	39,770	21
22	33	Real Estate Taxes	Resident Days	325,902	13			23,690		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			23,690		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		23,690	3	24
25	TOTALS					\$ 1,012,644	\$		\$ 73,611	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	US Bank		X	Mortgage	Varies	12/09/04	\$ 3,660,000	\$ 761,398	12/8/2011	0.0699	\$ 60,878
2											
3								Interest Income Offset			(4,578)
4								Home Office Allocation-PHC			7,705
5								Home Office Allocation-PHC II			39,770
	Working Capital										
6											
7											
8											
9	TOTAL Facility Related						\$ 3,660,000	\$ 761,398			\$ 103,775
	B. Non-Facility Related*										
10								Amortization of Loan Costs			280
11											
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$ 280
15	TOTALS (line 9+line14)						\$ 3,660,000	\$ 761,398			\$ 104,055

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

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

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

HFS 3745 (N-4-99)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2010 report.		\$	18,720	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.)	2010	\$	18,505	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(215)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	19,080	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.)		\$	394	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	19,259	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	16,257	8
	2007	16,822	9
	2008	17,585	10
	2009	18,155	11
	2010	18,505	12

Accrual based on prior year tax bill.

	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Mt. Vernon Health Care Center

COUNTY

Jefferson

FACILITY IDPH LICENSE NUMBER

0047928

CONTACT PERSON REGARDING THIS REPORT

Mark Petersen

TELEPHONE

(309)691-8113

FAX #:

(309) 691-8622

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-36-126-015	Long-Term Care Facility	\$ 18,504.72	\$ 18,504.72
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 18,504.72	\$ 18,504.72

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 21,285

B. General Construction Type: Exterior Block & BrickFrame BrickNumber of Stories 1
- C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	120,000	2005	\$ 60,000	1
2					2
3	TOTALS	120,000		\$ 60,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		2005	1970	\$ 1,190,500	\$	25	\$ 24,142	\$ 24,142	\$ 144,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2006	15,000		15	1,000	1,000	6,249	9
10	Durolast			2006	26,843		20	1,342	1,342	7,381	10
11	Sign front door			2006	3,118		20	156	156	858	11
12	Fire Alarm			2007	2,222		15	148	148	666	12
13	Roof Top Air Conditioner			2007	4,990		15	333	333	1,498	13
14	Sprinkler System			2008	86,980		39	2,230	2,230	7,805	14
15	Furnace			2008	6,600		5	1,320	1,320	4,620	15
16	Sewer Line Repair			2009	10,514		7	1,502	1,502	3,755	16
17	Sidewalks			2009	8,930		15	596	596	1,490	17
18	Nurses Station			2010	2,865		5	574	574	861	18
19	Backflow Preventer			2011	3,669		10	183	183	183	19
20	Water Heater			2011	3,745		10	187	187	187	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	Land Improvements Booked					1,595			(1,595)		28
29	Building Booked					47,620			(47,620)		29
30	Building Improvement Booked					7,497			(7,497)		30
31											31
32	2011-Home Office Allocation-Building Improvements				11,275			270	270		32
33	2011-Home Office Allocation-Land Improvements				1,053			67	67		33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

****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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,378,304	\$ 56,712		\$ 34,050	\$ (22,662)	\$ 180,073	70

**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	\$237,104	\$34,669	\$33,077	\$(1,592)	7-10 yrs.	\$178,649	71
72	Current Year Purchases	7,214	830	361	(469)	10 yrs.	361	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			23,349	23,349			74
75	TOTALS	\$244,318	\$35,499	\$56,787	\$21,288		\$179,010	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$1,682,622	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$92,211	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$90,837	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(1,374)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$359,083	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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 13,551 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 688.00	\$ 8,257	17
18					18
19					19
20					20
21	TOTAL		\$ 688.00	\$ 8,257	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual 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.

Mt. Vernon Health Care Center
0047928

Period Beginning	<u>1/1/2011</u>
Period End	<u>12/31/2011</u>

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 1,567
Dishwasher	1,008
Laundry Equipment	2,304
Copier	7,971
Home Office Allocation	<u>701</u>
	<u>13,551</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	☐ YES ☒ NO	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

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		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)	\$			

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.)

		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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				15		15	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				1,072		1,072	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 1,087		\$ 1,087	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.

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	\$ (48,611)	\$ (48,611)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	618,751	618,751	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,498	29,498	6
7	Other Prepaid Expenses	12,636	12,636	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Related Parties			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 612,274	\$ 612,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	1,274,430	1,201,775	14
15	Leasehold Improvements, at Historical Cost	121,585	176,529	15
16	Equipment, at Historical Cost	247,435	244,318	16
17	Accumulated Depreciation (book methods)	(489,694)	(359,083)	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)	\$ 1,153,756	\$ 1,323,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,766,030	\$ 1,935,813	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 421,682	\$ 421,682	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,634	93,634	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,271	5,271	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,080	19,080	32
33	Accrued Interest Payable	1,816	1,816	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	77,332	77,332	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 618,815	\$ 618,815	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	761,398	761,398	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)	\$ 761,398	\$ 761,398	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,380,213	\$ 1,380,213	46
47	TOTAL EQUITY(page 18, line 24)	\$ 385,817	\$ 555,600	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,766,030	\$ 1,935,813	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$346,852	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$346,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$38,967	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)	\$385,817	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mt. Vernon Health Care Center

0047928

Report Period Beginning: 1/1/2011

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,518,617	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,518,617	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,368	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	108	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,476	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,578	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,578	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Vending Revenue	637	28
28a	Transportation Revenue	5,283	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,920	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,532,591	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	553,824	31
32	Health Care	1,242,223	32
33	General Administration	442,005	33
	B. Capital Expense		
34	Ownership	193,341	34
	C. Ancillary Expense		
35	Special Cost Centers	4,196	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,493,624	40
41	Income before Income Taxes (line 30 minus line 40)**	38,967	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,967	43

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

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

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

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

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	1,957	1,957	\$ 60,524	\$ 30.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,510	7,598	156,358	20.58	3
4	Licensed Practical Nurses	13,761	14,157	243,187	17.18	4
5	CNAs & Orderlies	56,909	58,208	554,921	9.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,666	1,784	19,685	11.03	9
10	Activity Assistants	1,806	1,940	18,133	9.35	10
11	Social Service Workers	1,984	1,984	27,774	14.00	11
12	Dietician					12
13	Food Service Supervisor	1,582	1,670	21,922	13.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,152	17,427	82,702	4.75	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	41,914	20.15	17
18	Housekeepers	15,474	16,070	141,565	8.81	18
19	Laundry					19
20	Administrator	2,080	2,080	57,345	27.57	20
21	Assistant Administrator	1,863	1,863	19,846	10.65	21
22	Other Administrative					22
23	Office Manager	1,986	1,986	30,108	15.16	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	4,832	4,832	91,267	18.89	33
34	TOTAL (lines 1 - 33)	132,642	135,636	\$ 1,567,251 *	\$ 11.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,252	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,252		49

C. CONTRACT NURSES

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

Mt. Vernon Health Care Center

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	45,305	21.78
Restorative Aide	672	672	6,240	9.29
Alzheimer's Coordinator	2,080	2,080	39,722	19.10
TOTAL	4,832	4,832	91,267	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Carrell Breeze	Administrator	0	\$ 57,345	Workers' Compensation Insurance	\$ 34,713	IDPH License Fee	\$	
Lisa Dickey	Asst. Administrator	0	19,846	Unemployment Compensation Insurance	22,751	Advertising: Employee Recruitment	2,151	
				FICA Taxes	113,936	Health Care Worker Background Check		
				Employee Health Insurance	3,915	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	180 1,803	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	270	
				Employee Relations	235	Miscellaneous Dues & Subscriptions	400	
				Life Insurance	10,102	Home Office Allocation	639	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
\$ 77,191								
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 132,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			\$ 185,652	
\$ 132,000								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Charter Communications	Computer Services		\$ 1,091			\$	Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,855					
Honkamp, Kruger, & Co.	Accounting Services		476	N/A				
Brown & James	Legal Services		12,075				In-State Travel	
							Seminar Expense	
							Home Office Allocation	47
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			(agree to Sch. V, line 24, col. 8)	
\$ 16,497							TOTAL \$ 47	

*** Attach copy of IMRF notifications**

****See instructions.**

Mt. Vernon Health Care Center
0047928
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		16,497
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	6
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	759
Miscellaneous Vendors	Computer Services	62
Advanced Answers on Demand	Computer Services	3,171
Access 2 Go	Computer Services	312
Kemper Technology	Computer Services	145
MediFax	Computer Services	49
VisionShare/Ability Network	Computer Services	223
Advanced System Design	Computer Services	292
Simple LTC	Computer Services	367
Optimizer Systems	Other Prof Fees	37
Clifton Gunderson	Other Prof Fees	13
Mike Miller	Other Prof Fees	18
OIC Group	Other Prof Fees	4
AllScripts	Other Prof Fees	10
Miscellaneous Vendors	Legal	2
Ginoli & Company	Accountants	1,255
U.S. Bank	Accountants	723
CDW	Computer Services	772
Polaris Group	Professional Fees	740
Total (agree to Schedule V, line 19, column 8)		25,458

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Brown and James	10,932.56	100%	10,933
Brown and James	1,142.30	100%	1,142
Home Office Allocation			
Heyl, Royster, Voelker & Allen	375	1.60%	6
Henry County Recorder	41	2.44%	1
Miscellaneous Vendors	29	6.90%	2
Total Legal Fees			12,084

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,701 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,368
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,110

c. What percent of all travel expense relates to transportation of nurses and patients? N/A

d. Have vehicle usage logs been maintained? Adequate records have been maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees