

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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 East IL Hwy 15</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# 0035998 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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>12,078</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</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>36,966</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>524</u>	<u>526</u>	<u>6,002</u>	<u>7,052</u>	8
9	SNF/PED					9
10	ICF	<u>16,935</u>	<u>5,343</u>		<u>22,278</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,459</u>	<u>5,869</u>	<u>6,002</u>	<u>29,330</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.34%

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?

YesG. 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 32and days of care provided 6,002Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	170,753	7,882	8,745	187,380		187,380		187,380		1
2	Food Purchase		132,691		132,691		132,691	(1,464)	131,227		2
3	Housekeeping	74,880	16,970		91,850		91,850	1,010	92,860		3
4	Laundry	98,868	10,324		109,192		109,192		109,192		4
5	Heat and Other Utilities			84,496	84,496		84,496	(5,638)	78,858		5
6	Maintenance	67,474	78,482	1,020	146,976		146,976	47,271	194,247		6
7	Other (specify):* Sanitation			8,769	8,769		8,769		8,769		7
8	TOTAL General Services	411,975	246,349	103,030	761,354		761,354	41,179	802,533		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,594,801	114,120	3,913	1,712,834		1,712,834		1,712,834		10
10a	Therapy										10a
11	Activities	41,148	2,719	2,026	45,893		45,893		45,893		11
12	Social Services	59,815			59,815		59,815		59,815		12
13	CNA Training										13
14	Program Transportation		10,714		10,714		10,714		10,714		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,695,764	127,553	11,939	1,835,256		1,835,256		1,835,256		16
	C. General Administration										
17	Administrative	70,078	15,675	829,722	915,475	(6,183)	909,292	(572,301)	336,991		17
18	Directors Fees										18
19	Professional Services			15,117	15,117		15,117	9,510	24,627		19
20	Dues, Fees, Subscriptions & Promotions			15,376	15,376	5,405	20,781	(9,014)	11,767		20
21	Clerical & General Office Expenses	26,908	18,477	117,482	162,867	778	163,645	68,732	232,377		21
22	Employee Benefits & Payroll Taxes			418,997	418,997		418,997	22,969	441,966		22
23	Inservice Training & Education			903	903		903		903		23
24	Travel and Seminar			5,156	5,156		5,156	859	6,015		24
25	Other Admin. Staff Transportation							5,725	5,725		25
26	Insurance-Prop.Liab.Malpractice			47,465	47,465		47,465	1,882	49,347		26
27	Other (specify):*										27
28	TOTAL General Administration	96,986	34,152	1,450,218	1,581,356		1,581,356	(471,638)	1,109,718		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,204,725	408,054	1,565,187	4,177,966		4,177,966	(430,459)	3,747,507		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			166,379	166,379		166,379	14,095	180,474			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			145,657	145,657		145,657	1,066	146,723			33
34	Rent-Facility & Grounds			6,500	6,500		6,500	(6,500)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			318,536	318,536		318,536	8,661	327,197			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		194,766	647,303	842,069		842,069		842,069			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			264,957	264,957		264,957		264,957			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		194,766	912,260	1,107,026		1,107,026		1,107,026			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,204,725	602,820	2,795,983	5,603,528		5,603,528	(421,798)	5,181,730			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

Facility Name & ID Number Mt Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2012 Ending: 12/31/2012
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(580)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,071)	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	(884)	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	(183)	17		17
18	Fines and Penalties				18
19	Entertainment	(4,250)	17		19
20	Contributions	(893)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(664)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,944)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,656)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,748)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,873)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(393,925)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (393,925)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (421,798)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mt Vernon Countryside ManorID# 0035998Report Period Beginning: 01/01/2012Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate Lobbying Portion of 2012 IHCA Dues	\$ (1,952)	20	1
2	Straight Line Depr. On Items Req'd To Be Capitalized	1,202	30	2
3	Offset Bank-Related Reimbursements	(8)	17	3
4	Eliminate 2013 IDPH License paid in 2012	(1,990)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,748)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mt Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,464)	0	0	0	0	0	0	0	0	0	0	(1,464)	2
3	Housekeeping	0	1,010	0	0	0	0	0	0	0	0	0	1,010	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,071)	1,433	0	0	0	0	0	0	0	0	0	(5,638)	5
6	Maintenance	0	47,271	0	0	0	0	0	0	0	0	0	47,271	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,535)	49,714	0	0	0	0	0	0	0	0	0	41,179	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(4,441)	113,337	(681,197)	0	0	0	0	0	0	0	0	(572,301)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(664)	8,032	2,142	0	0	0	0	0	0	0	0	9,510	19
20	Fees, Subscriptions & Promotions	(9,779)	747	18	0	0	0	0	0	0	0	0	(9,014)	20
21	Clerical & General Office Expenses	(5,656)	74,388	0	0	0	0	0	0	0	0	0	68,732	21
22	Employee Benefits & Payroll Taxes	0	18,392	4,577	0	0	0	0	0	0	0	0	22,969	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	859	0	0	0	0	0	0	0	0	859	24
25	Other Admin. Staff Transportation	0	5,725	0	0	0	0	0	0	0	0	0	5,725	25
26	Insurance-Prop.Liab.Malpractice	0	1,882	0	0	0	0	0	0	0	0	0	1,882	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,540)	222,503	(673,601)	0	0	0	0	0	0	0	0	(471,638)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(29,075)	272,217	(673,601)	0	0	0	0	0	0	0	0	(430,459)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,202	12,893	0	0	0	0	0	0	0	0	0	14,095	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	1,066	0	0	0	0	0	0	0	0	0	1,066	33
34	Rent-Facility & Grounds	0	0	(6,500)	0	0	0	0	0	0	0	0	(6,500)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,202	13,959	(6,500)	0	0	0	0	0	0	0	0	8,661	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(27,873)	286,176	(680,101)	0	0	0	0	0	0	0	0	(421,798)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Denise King 2012 Exempt Trust	20	Aviston Countryside Manor, Inc.	Aviston	King Management	Nashville, IL	Home Office
Leslie Pedtke 2012 Exempt Trust	20	Taylorville Care Center, Inc.	Taylorville	King Management	Bonita Springs, FL	Management Co.
Keith King 2012 Exempt Trust	20			of SW Florida		
Elizabeth Todorov 2012 Exempt Trust	20			Residential Living Ctr	Mt. Vernon	Assisted Living
Michelle Hirschfeld 2012 Exempt Trust	20			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 Company	100.00%	\$ 1,010	\$ 1,010	1
2	V	5	See Schedule VIII		King Management Company	100.00%	1,433	1,433	2
3	V	6	See Schedule VIII		King Management Company	100.00%	47,271	47,271	3
4	V	17	See Schedule VIII		King Management Company	100.00%	113,337	113,337	4
5	V	19	See Schedule VIII		King Management Company	100.00%	8,032	8,032	5
6	V	20	See Schedule VIII		King Management Company	100.00%	747	747	6
7	V	21	See Schedule VIII		King Management Company	100.00%	74,388	74,388	7
8	V	22	See Schedule VIII		King Management Company	100.00%	18,392	18,392	8
9	V	25	See Schedule VIII		King Management Company	100.00%	5,725	5,725	9
10	V	26	See Schedule VIII		King Management Company	100.00%	1,882	1,882	10
11	V	30	See Schedule VIII		King Management Company	100.00%	12,893	12,893	11
12	V	33	See Schedule VIII		King Management Company	100.00%	1,066	1,066	12
13	V								13
14	Total			\$			\$ 286,176	\$ * 286,176	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.

☒ X

 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	\$ 6,500	Jerry & Marilyn King		\$	\$ (6,500)	15
16	V								16
17	V	17	See Schedule VIII	829,722	King Management of SW Florida	100.00%	148,525	(681,197)	17
18	V	19	See Schedule VIII		King Management of SW Florida	100.00%	2,142	2,142	18
19	V	20	See Schedule VIII		King Management of SW Florida	100.00%	18	18	19
20	V	22	See Schedule VIII		King Management of SW Florida	100.00%	4,577	4,577	20
21	V	24	See Schedule VIII		King Management of SW Florida	100.00%	859	859	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			\$ 836,222			\$ 156,121	\$ * (680,101)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Mgt. Co. Owner	Mgmt/Consultant	0.00	264,279	16	32.26	Salary	\$ 146,590	17, 8	1
2	Denise King	V.P. of Operations	Administrative	20.00	203,565	19	32.26	Salary	112,913	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	20.00	83,500	16	32.26	Salary	46,316	6, 8	3
4	Marilyn King	Mgt. Co. Owner	Mgmt/Consultant	0.00	3,490	1	32.26	Salary	1,935	17, 8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 307,754		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

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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	133,000	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.)		\$	137,857	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	4,857	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	140,800	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.		\$	145,657	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	93,882	8	
		2008	107,793	9	
		2009	131,510	10	
		2010	131,118	11	
		2011	137,857	12	
Line 4: Accrual is based on 2011 taxes paid.					
Line 7: Real Estate Tax Expense \$145,657					
Home Office Allocation 1,066					
Total Real Estate Tax \$146,723					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2011 \$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Mt Vernon Countryside Manor

COUNTY
Jefferson

FACILITY IDPH LICENSE NUMBER
0035998

CONTACT PERSON REGARDING THIS REPORT
Linda Peppenhorst

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-28-376-013	LMC Plaza - Lots 1 thru 5	\$ 220,837.66	\$ 137,856.82
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 220,837.66	\$ 137,856.82

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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	2,029	2
3	TOTALS			\$ 97,283	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$	\$ 2,058,870	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping		1990		26,544		10			26,544	9
10	Parking Lot		1990		26,563		10			26,563	10
11	Door & Screen		1992		1,700		10			1,700	11
12	Vanity & Medicine Cabinet		1992		1,136		10			1,136	12
13	Garage		1993		7,238		15			7,238	13
14	Water Heater		1995		2,960		15			2,960	14
15	Smoke Detectors		1996		812		10			812	15
16	Air Conditioners (2)		1996		1,342		5			1,342	16
17	Multiflow Furnace/Condensing Unit		1996		1,541		5			1,541	17
18	Storage Building Roof		1996		5,100		10			5,100	18
19	Asphalt East Parking Lot		1996		2,373		10			2,373	19
20	Air Conditioners (2)		1996		1,549		5			1,549	20
21	Entry Control System		1996		1,133		10			1,133	21
22	Vinyl Floor Covering		1996		4,465		10			4,465	22
23	Fire Alarm System		1997		13,564	226	15	226		13,564	23
24	Furnance & Tempering Valve		1997		2,112	24	15	24		2,112	24
25	Air Conditioners (2)		1997		1,502		10			1,502	25
26	Water Heater		1998		3,273	218	15	218		3,273	26
27	Air Freshner System		1998		1,314		10			1,314	27
28	Air Freshner System		1998		1,300		10			1,300	28
29	Gazebo		1998		2,974	198	15	198		2,875	29
30	Water Heater		1999		3,414	228	15	228		3,092	30
31	Water Heater		1999		2,429	162	15	162		2,200	31
32	Carpet		2000		9,666		10			9,666	32
33	Flooring		2000		18,661		10			18,661	33
34	Concrete Pad for Gazebo		2000		4,303		15	287	287	3,610	34
35	Landscaping		2001		7,305		10			7,305	35
36	Electrical Repairs		2001		6,691		10			6,691	36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Heater	2001	\$ 2,745	\$ 183	15	\$ 183	\$	\$ 2,196	37
38	Cabinets	2001	28,181	1,409	20	1,409		16,674	38
39	Office Remodel	2002	5,319	355	15	355		3,694	39
40	Wall Brackets	2002	4,577	114	10	114		4,577	40
41	Shower Room Tile	2002	3,108	259	10	259		3,108	41
42	Air Conditioners (8)	2002	6,164		5			6,164	42
43	Air Conditioners (7)	2003	5,220		5			5,220	43
44	Telephone System	2003	9,538	954	10	954		8,902	44
45	Air Conditioners (5)	2003	4,683		5			4,683	45
46	Water Softener System	2003	6,199	517	12	517		5,123	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		3,070	51
52	Concrete Driveway	2004	4,257	284	15	284		2,365	52
53	Landscaping	2005	20,005	2,000	10	2,000		14,337	53
54	Lighting - 300 Hall Exit	2005	3,269	327	10	327		2,479	54
55	HVAC Units (3)	2005	2,417		5			2,417	55
56	Sprinkler Pipe Replacement	2006	36,670	1,467	25	1,467		9,534	56
57	Parking Lot Slab	2006	22,000	1,467	15	1,467		9,289	57
58	Window Treatment	2006	16,296	1,630	10	1,630		10,049	58
59	Painting & Wallpapering	2006	29,844		5			29,844	59
60	Flooring	2006	62,193	6,219	10	6,219		38,353	60
61	Heating & Cooling Units (7)	2006	3,731	373	10	373		2,363	61
62	Water Heater	2006	5,525	552	10	552		3,729	62
63	Water Heater	2006	5,153	515	10	515		3,564	63
64	Wallguards	2006	3,478		5			3,478	64
65	Light Fixtures	2006	1,278	128	10	128		788	65
66	Wallguard	2007	2,191	219	10	219		1,297	66
67	Nurse Station Flooring	2007	10,127	1,013	10	1,013		5,907	67
68	Custom Nurse Station	2007	17,030	1,419	12	1,419		8,278	68
69	Custom Cabinetry and Tops	2007	11,369	947	12	947		5,527	69
70	TOTAL (lines 4 thru 69)		\$ 3,252,248	\$ 114,596		\$ 114,883	\$ 287	\$ 2,463,827	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,252,248	\$ 114,596		\$ 114,883	\$ 287	\$ 2,463,827	1
2									2
3	New Roof	2007	90,380	9,038	10	9,038		51,969	3
4	Blinds	2007	2,019	101	5	101		2,019	4
5	Gutters	2007	6,500	650	10	650		3,683	5
6	Commercial Heater	2007	5,846	585	10	585		3,410	6
7	Iron Fence	2008	21,585	863	25	863		4,101	7
8	Lighted Fountain	2008	3,331	222	15	222		1,036	8
9	Doors	2010	1,506	100	15	100		226	9
10	Sprinkler System Heads (53)	2010	8,441	338	25	338		816	10
11	Satellite Dishes	2010	13,900	1,390	10	1,390		3,128	11
12	Interior Doors (161)	2010	94,717	6,314	15	6,314		13,155	12
13	Water Heaters (2)	2011	9,459	946	10	946		1,575	13
14	Air Conditioning System - 3-ton	2011	6,800	1,360	5	1,360		2,380	14
15	Water Softeners (2)	2011	4,345	434	10	434		579	15
16	Bridge Upgrade - Concrete	2011	10,718	715	15	715		1,012	16
17	Water Heaters (2)	2012	15,222	635	10	635		635	17
18	Air Conditioner - 5-ton	2012	4,850	242	10	242		242	18
19	Walk-In Cooler Condensing Unit	2012	2,638	73	15	73		73	19
20	PTAC Heating & Cooling Units (10)	2012	7,333	163	15	163		163	20
21									21
22	Home Office Parking Lot	1989	638		5			638	22
23	Home Office New Building	1995	31,623		25	1,265	1,265	21,715	23
24	Home Office Interior Finishes	1996	1,961		15			1,961	24
25	Home Office Carpet	1996	686		5			686	25
26	Home Office Cabinets	1996	1,085		20	54	54	895	26
27	Home Office Electrical	1996	376		15			376	27
28	Home Office Front Door	2002	516		10	39	39	516	28
29	Home Office Wallpaper	2007	295		10	29	29	152	29
30	Home Office Wallpaper	2008	2,420		5	484	484	2,420	30
31	Home Office Carpet	2008	2,982		5	596	596	2,982	31
32	Home Office Tile Flooring	2009	207		10	21	21	83	32
33	Home Office Wallpaper	2009	463		5	93	93	370	33
34	TOTAL (lines 1 thru 33)		\$ 3,605,090	\$ 138,765		\$ 141,633	\$ 2,868	\$ 2,586,823	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	\$242,033	\$19,704	\$23,106	\$3,402	3-15 years	\$111,593	71
72	Current Year Purchases	24,714	7,910	7,910		3-10 years	7,911	72
73	Fully Depreciated Assets	565,727					565,727	73
74								74
75	TOTALS	\$832,474	\$27,614	\$31,016	\$3,402		\$685,231	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2000 Chevy LS Van w/Lift	2001	\$22,659	\$	\$	\$	4	\$22,659	76
77	Facility	2003 Ford Supreme Shuttle Bus	2003	40,750				4	40,750	77
78	Facility	Utility Trailer	2004	1,867				4	1,867	78
79	Home Office Vehicles	Various	Various	26,860		7,825	7,825	4	4,146	79
80	TOTALS			\$92,136	\$	\$7,825	\$7,825		\$69,422	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,626,983	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$166,379	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$180,474	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$14,095	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,341,476	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Section 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 ☒ N/A 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. /2013 \$
13. /2014 \$
14. /2015 \$

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.
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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				194,766		194,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Therapy</u>	39,3				583,596			583,596	12
13	Other (specify): <u>Labs, X-Rays, Ambul.</u>	39,3				63,707			63,707	13
14	TOTAL			\$		\$ 647,303	\$ 194,766		\$ 842,069	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 682,966	\$	1
2	Cash-Patient Deposits	1,766		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	1,163,902		3
4	Supply Inventory (priced at Cost)	9,743		4
5	Short-Term Investments			5
6	Prepaid Insurance	49,353		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	21,655		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,929,385	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,554,699		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	843,116		16
17	Accumulated Depreciation (book methods)	(3,255,908)		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)	\$ 1,141,907	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,071,292	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 279,951	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,766		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,374		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,456		31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Management Company	97,936		36
37	Accrued Medicare Billing Fees	20,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 747,283	\$	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)	\$ 747,283	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,324,009	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,071,292	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,944,378	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,944,378	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	381,942	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	(2,311)	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)	\$ 379,631	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)	\$ 2,324,009	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mt Vernon Countryside Manor# 0035998Report Period Beginning: 01/01/2012Ending: 12/31/2012**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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,562,135	1
2	Discounts and Allowances for all Levels	(657,371)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,904,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,023,970	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,023,970	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	300	13
14	Non-Patient Meals	580	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	54,435	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,315	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,413	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,413	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bank-Related Reimbursements	8	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,985,470	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	761,354	31
32	Health Care	1,835,256	32
33	General Administration	1,581,356	33
	B. Capital Expense		
34	Ownership	318,536	34
	C. Ancillary Expense		
35	Special Cost Centers	842,069	35
36	Provider Participation Fee	264,957	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,603,528	40
41	Income before Income Taxes (line 30 minus line 40)**	381,942	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 381,942	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,254,912	44
45	Private Pay - Net Inpatient Revenue	941,573	45
46	Medicare - Net Inpatient Revenue	1,708,279	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,904,764	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1,803	2,115	\$ 57,905	\$ 27.38	1
2	Assistant Director of Nursing	2,036	2,290	49,847	21.77	2
3	Registered Nurses	17,442	19,084	386,204	20.24	3
4	Licensed Practical Nurses	14,771	16,103	272,002	16.89	4
5	CNAs & Orderlies	78,605	80,066	814,301	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,686	4,168	41,148	9.87	10
11	Social Service Workers	4,026	4,616	59,815	12.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,485	16,957	170,753	10.07	15
16	Dishwashers					16
17	Maintenance Workers	3,776	4,272	67,474	15.79	17
18	Housekeepers	8,138	8,487	74,880	8.82	18
19	Laundry	11,096	11,448	98,868	8.64	19
20	Administrator	1,771	2,115	70,078	33.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,904	2,236	26,908	12.03	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	1,137	1,331	14,542	10.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,676	175,288	\$ 2,204,725 *	\$ 12.58	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	144	\$ 7,462	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	17	994	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,919	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	2,026	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	188	\$ 19,401		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.

STATE OF ILLINOIS

Facility Name & ID Number

Report Period Beginning:

Page 21

0035998

Mt Vernon Countryside Manor

01/01/2012

Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marla Howard	Administrator	0	\$ 70,078
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,078

B. Administrative - Other

Description	Amount
Management Fee	\$ 829,722
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 829,722

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	\$ 12,845
Greensfelder, Hemker & Gale	Legal Fees	1,608
Mathis, Marifian & Richter	Collection Fees - Eliminated	664
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 15,117

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 174,673
Unemployment Compensation Insurance	38,767
FICA Taxes	166,092
Employee Health Insurance	35,863
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,653
Pension Expense	1,847
Employee Physicals	102
Home Office Allocation	18,392
Management Company Allocation	4,577
TOTAL (agree to Schedule V, line 22, col.8)	\$ 441,966

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 21)	630
Patient Background Checks	300
IHCA Dues	3,292
Miscellaneous Dues & Licenses	1,710
Subscriptions	380
Home Office Allocation	747
Management Company Allocation	18
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,767

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	2,840
Seminar Expense	2,316
Management Company Allocation	859
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 6,015

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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 \$3,292
- (3)

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

Yes

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

Yes
- (4)

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

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

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

3-10 years
- (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.

\$ 264,957

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.

\$ 580
- (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?

64%

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?

N/A

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
12/31/2012

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	\$ 5,405
CLERICAL & GENERAL OFFICE	21	778
ADMINISTRATIVE	17	(6,183)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
LICENSES & FEES	\$ 1,150	
OFFICE EXPENSES	778	
BACKGROUND CHECKS	3,630	
SUBSCRIPTIONS	380	
DUES	245	
TOTAL	\$ <u>6,183</u>	

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

BOOK TO TAX RECONCILIATION:

BOOK NET INCOME	\$ 381,942
DEPRECIATION ADJUSTMENT	34,852
TRAVEL & ENTERTAINMENT ADJUSTMENT	2,125
ILLINOIS REPLACEMENT TAXES	5,562
CONVERSION TO CASH BASIS ADJUSTMENTS	(63,338)
POLITICAL CONTRIBUTIONS ADJUSTMENT	333
TAX NET INCOME	<u>\$ 361,476</u>

MT. VERNON COUNTRYSIDE MANOR
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2012

NAME OF EMPLOYEE ATTENDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR
Erin Wallace	Social Services	01/26/12	Breese	Achieving Excellence in Social Services	Outcome Services of IL
Tyger Downen	Social Services	01/26/12	Breese	Achieving Excellence in Social Services	Outcome Services of IL
Rhonda Moffitt	Activities	03/29/12	Carlyle	MDS 3.0 Update	Outcome Services of IL
Keisha Smith	MDS Coordinator	03/27/12	Mt. Vernon	Webinar - MDS 3.0: What's New? What's Not?	IHCA
Sophie Rudd	Care Plan Coordinator	03/27/12	Mt. Vernon	Webinar - MDS 3.0: What's New? What's Not?	IHCA
Dana Bower	Dietary	03/27/12	Mt. Vernon	Webinar - MDS 3.0: What's New? What's Not?	IHCA
Erin Wallace	Social Services	03/27/12	Mt. Vernon	Webinar - MDS 3.0: What's New? What's Not?	IHCA
Rhonda Moffitt	Activities	03/27/12	Mt. Vernon	Webinar - MDS 3.0: What's New? What's Not?	IHCA
Marla Howard	Administrator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Jeanette Mostyn	Director of Nursing	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Denise King	President	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Dana Bower	Dietary	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Tyger Downen	Social Services	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Lacey Moffitt	Assistant Director of Nursing	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Sophie Rudd	Care Plan Coordinator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Keisha Smith	MDS Coordinator	09/10/12 - 09/13/12	Peoria	IHCA Convention	IHCA
Marla Howard	Administrator	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition
Erin Wallace	Social Services	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition
Chris Wreath	Office Manager	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition
Denise King	President	10/08/12 - 10/10/12	Springfield	IL Pioneer Summit	IL Pioneer Coalition
Marla Howard	Administrator	10/30/12 - 10/31/12	Springfield	INHAA Convention	INHAA
Jeanette Mostyn	Director of Nursing	11/08/12	Effingham	New OBRA Standards for Tube Feeding	IHCA
Keisha Smith	MDS Coordinator	11/08/12	Effingham	New OBRA Standards for Tube Feeding	IHCA

Management Company Allocat

SEMINAR	TRAVEL/ LODGING
COST	COST
85	
85	
80	
15	
15	
15	
15	
15	
107	223
107	223
107	223
107	223
107	222
107	222
107	222
106	222
174	100
174	100
174	100
174	99
250	661
95	
95	
2,316	2,840
	5,156
ation	859
	6,015

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

OTHER CURRENT ASSETS:

INVESTMENT IN LTC INSURANCE	\$ 20,705
UTILITY DEPOSIT	950
	<u>\$ 21,655</u>

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

<u>Name</u>	<u>Aviston Countryside Manor</u>	<u>Taylorville Care Center</u>	<u>Total Schedule VII C Column 5</u>
Jerry King	\$ 145,477	\$ 118,802	\$ 264,279
Denise King	112,056	91,509	203,565
Keith King	45,964	37,536	83,500
Marilyn King	1,921	1,569	3,490
Total	<u>\$ 305,418</u>	<u>\$ 249,416</u>	<u>\$ 554,834</u>