

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0035998

Facility Name: Mount Vernon Cntryside Manor

Address: 606 East IL Hwy 15 Mount Vernon 62864
Number City Zip Code

County: Jefferson

Telephone Number: (618) 242-1800 Fax # (618) 242-9080

HFS ID Number:

Date of Initial License for Current Owners: 05/09/1990

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

In the event there are further questions about this report, please contact:
Name: Amy Elik, Chief Financial Officer Telephone Number: (618) 327-3064 ext227
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 01/01/2016 to 12/31/2016 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) Denise King
(Title) President

Paid
Preparer

(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

Facility Name & ID Number Mount Vernon Cntryside Manor

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

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,078</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,228</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>91</u>	TOTALS	<u>91</u>	<u>33,306</u>	7

B. Census-For the entire report period.

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

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐

NO ☒

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

YES ☐

NO ☒

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

Date started

05/09/1990

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

YES ☐

Date

NO ☒

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

YES ☒

NO ☐

If YES, enter number

of beds certified

32

and days of care provided

4,692

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED CASH* ☐

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒

NO ☐

Tax Year:

12/31/2016

Fiscal Year:

12/31/2016

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

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

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

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

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

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

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			170,814	170,814		170,814	6,036	176,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12	12		12		12			32
33	Real Estate Taxes			146,863	146,863		146,863		146,863			33
34	Rent-Facility & Grounds							6,244	6,244			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			317,689	317,689		317,689	12,280	329,969			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,870	597,901	780,771		780,771		780,771			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,922	193,922		193,922		193,922			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		182,870	791,823	974,693		974,693		974,693			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,280,415	520,588	1,966,485	4,767,488		4,767,488	(2,864)	4,764,624			45

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

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

Activities	Line 11	94
Social Services	Line 12	(94)

Reclass cost of activities consultant to correct line

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

Reclass accounting fees to correct line

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

Reclass seminar expenses to correct line

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

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 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)	41,554	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,554		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,864)		37

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

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

		1 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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Cntryside Manor# 0035998

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

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

STATE OF ILLINOIS

Summary B

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

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

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

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	0.00%	\$ 430	\$ 430	1
2	V	5	See Schedule VIII		King Management Company	0.00%	1,165	1,165	2
3	V	6	See Schedule VIII		King Management Company	0.00%	3,992	3,992	3
4	V	17	See Schedule VIII	210,000	King Management Company	0.00%	114,503	(95,497)	4
5	V	19	See Schedule VIII		King Management Company	0.00%	4,054	4,054	5
6	V	20	See Schedule VIII		King Management Company	0.00%	251	251	6
7	V	21	See Schedule VIII		King Management Company	0.00%	98,694	98,694	7
8	V	22	See Schedule VIII		King Management Company	0.00%	14,232	14,232	8
9	V	24	See Schedule VIII		King Management Company	0.00%	153	153	9
10	V	25	See Schedule VIII		King Management Company	0.00%	466	466	10
11	V	26	See Schedule VIII		King Management Company	0.00%	1,334	1,334	11
12	V	30	See Schedule VIII		King Management Company	0.00%	6,036	6,036	12
13	V	34	See Schedule VIII		King Management Company	0.00%	6,244	6,244	13
14	Total			\$ 210,000			\$ 251,554	\$ * 41,554	14

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Denise King	President	Administrative	20.00	185,362	14	35.00	Salary	\$ 114,401	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 114,401		13

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

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

Facility Name & ID Number	Mount Vernon Cntryside Manor
--------------------------------------	-------------------------------------

0035998

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

King Management Company

Street Address

1670 Essex Way, Suite B

City / State / Zip Code

O'Fallon, IL 62269

Phone Number

((618) 327-3064

Fax Number

((618) 327-3083

	1 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	3	Housekeeping	Accumulated Costs	13,397,043	6	\$ 1,264	\$	4,557,488	\$ 430	1
2	5	Utilities	Accumulated Costs	13,397,043	6	3,425		4,557,488	1,165	2
3	6	Maintenance	Accumulated Costs	13,397,043	6	11,735		4,557,488	3,992	3
4	17	Administrative	Accumulated Costs	13,397,043	6	336,590	336,291	4,557,488	114,503	4
5	19	Professional Services	Accumulated Costs	13,397,043	6	11,916		4,557,488	4,054	5
6	20	Dues, Fees, & Subscriptions	Accumulated Costs	13,397,043	6	739		4,557,488	251	6
7	21	Clerical & Office Expense	Accumulated Costs	13,397,043	6	290,118	237,401	4,557,488	98,694	7
8	22	Emp Benefits & Payroll Taxes	Accumulated Costs	13,397,043	6	41,836		4,557,488	14,232	8
9	24	Travel & Seminar	Accumulated Costs	13,397,043	6	450		4,557,488	153	9
10	25	Other Administrative Transp.	Accumulated Costs	13,397,043	6	1,371		4,557,488	466	10
11	26	Insurance	Accumulated Costs	13,397,043	6	3,922		4,557,488	1,334	11
12	30	Depreciation	Accumulated Costs	13,397,043	6	17,743		4,557,488	6,036	12
13	34	Rent-Facility & Grounds	Accumulated Costs	13,397,043	6	18,355		4,557,488	6,244	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 739,464	\$ 573,692		\$ 251,554	25

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Interest on Medicare Recoupments											12	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	12	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$	12	15

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

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

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

FACILITY NAME Mount Vernon Cntryside Manor COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0035998

CONTACT PERSON REGARDING THIS REPORT Amy Elik

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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.

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 Mt Vernon Countryside Manor.

E. 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	\$ 61,425	1
2					2
3	TOTALS			\$ 61,425	3

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

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

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

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

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

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning:

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,639,191	\$ 136,983		\$ 136,983	\$	\$ 3,110,398	1
2								2
3								3
4 Home Office Additions:								4
5 Front Door-disposed in 2016	2002			10				5
6 Wallpaper-disposed in 2016	2007			10	13	13		6
7 Wallpaper-disposed in 2016	2008			5				7
8 Carpet-disposed in 2016	2008			5				8
9 Tile Flooring-disposed in 2016	2009			10	9	9		9
10 Wallpaper-disposed in 2016	2009			5				10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,639,191	\$ 136,983		\$ 137,005	\$ 22	\$ 3,110,398	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$234,079	\$31,440	\$33,264	\$1,824	3-15 Yrs	\$178,704	71
72	Current Year Purchases	67,610	2,391	3,872	1,481	3-15 Yrs	3,872	72
73	Fully Depreciated Assets	464,425					464,425	73
74								74
75	TOTALS	\$766,114	\$33,831	\$37,136	\$3,305		\$647,001	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2000 Chevy LS van w/ Lift	2001	\$22,659	\$	\$	\$	4	\$22,659	76
77	Facility	2003 Ford Supreme Shuttle Bus	2003	40,750				4	40,750	77
78	Facility	Utility Trailer	2004	1,867				4	1,867	78
79	Home Office Vehicle	2012 Acura	2012	10,837		2,709	2,709	4	10,837	79
80	TOTALS			\$76,113	\$	\$2,709	\$2,709		\$76,113	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,542,843	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$170,814	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$176,850	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$6,036	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,833,512	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☒ N/A NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ N/A NO
16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		\$	\$	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(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.)

12345678											
	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				182,474		182,474	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): Therapy	39,3				547,177			547,177	12	
13	Other (specify): Labs,X-Ray,Ambul,Su	39,3 & 39,2				50,724	396		51,120	13	
14	TOTAL			\$		\$ 597,901	\$ 182,870		\$ 780,771	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,136,264	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,136,264	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	892,146	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,559,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (667,354)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,468,910	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mount Vernon Cntryside Manor

0035998

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,685,578	1
2	Discounts and Allowances for all Levels	(2,087,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,597,882	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,006,150	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,006,150	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	842	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,758	19
20	Radiology and X-Ray	25,106	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,706	23
	D. Non-Operating Revenue		
24	Contributions	239	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 239	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,507	28
28a	Misc Rental Income	6,150	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,659,634	30

2

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

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

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

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

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

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

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

BOOK TO TAX RECONCILIATION:

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	132	\$ 7,139	1,3	35
36	Medical Director	Contract	6,500	9,3	36
37	Medical Records Consultant	20	1,300	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	2,808	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,629	11,3	44
45	Social Service Consultant	23	1,628	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 21,004		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Tyger Downen	Administrator	0	\$ 71,612	Workers' Compensation Insurance	\$	50,649	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		40,443	Advertising: Employee Recruitment	853	
				FICA Taxes		165,352	Health Care Worker Background Check		
				Employee Health Insurance		43,415	(Indicate # of checks performed 175)	1,750	
				Employee Meals			Fingerprinting	1,000	
				Illinois Municipal Retirement Fund (IMRF)*			IHCA Dues	3,355	
				Employee Physicals		817	Miscellaneous Dues & Licenses	1,547	
				Employee Relations		2,525			
				Pension Expense-Employer Contribution		1,752	Home Office Allocation	251	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
				Home Office Allocation		14,232	Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,746	
				TOTAL (agree to Schedule V, line 22, col.8)					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description			Description		
Amount				Line #			Amount		
Management Fee - King Management Company				Section N/A			Out-of-State Travel		
							In-State Travel		
							Seminar Expense		
							Home Office Allocation		
							Entertainment Expense		
							()		

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

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?
If YES, give association name and amount.

Yes
IHCA Dues \$3,355

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
5-10 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

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

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 193,922

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ None
Yes 842

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

N/A

d.

Have vehicle usage logs been maintained?

Yes

e.

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

Yes

f.

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

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
No

(17)

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

No
N/A

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

Yes