

Facility Name & ID Number Countryview Care Center-Macomb

0047431 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	16	Skilled (SNF)	16	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	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			1,094	1,094	8
9	SNF/PED					9
10	ICF	13,349	1,738		15,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,349	1,738	1,094	16,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.50%

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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 10/01/05

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

YES Date 10/01/05 NO

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

YES NO If YES, enter number

of beds certified 16 and days of care provided 1,094

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Countryview Care Center-Macomb # 0047431 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	95,099	4,969	4,749	104,817		104,817	1,608	106,425		1
2	Food Purchase		78,083		78,083		78,083	(10,499)	67,584		2
3	Housekeeping	57,977	8,637		66,614		66,614	52	66,666		3
4	Laundry	42,522	11,979		54,501		54,501		54,501		4
5	Heat and Other Utilities			40,734	40,734		40,734	213	40,947		5
6	Maintenance	17,161	15,277	5,388	37,826		37,826	3,986	41,812		6
7	Other (specify):* Home Office Benefits							1,001	1,001		7
8	TOTAL General Services	212,759	118,945	50,871	382,575		382,575	(3,639)	378,936		8
	B. Health Care and Programs										
9	Medical Director			5,269	5,269		5,269		5,269		9
10	Nursing and Medical Records	491,011	64,788	1,573	557,372		557,372	4,966	562,338		10
10a	Therapy	49,628		27,778	77,406		77,406	382	77,788		10a
11	Activities	19,272	1,347	5,270	25,889		25,889		25,889		11
12	Social Services	28,705			28,705		28,705		28,705		12
13	CNA Training										13
14	Program Transportation			739	739		739		739		14
15	Other (specify):* Home Office Benefits							1,562	1,562		15
16	TOTAL Health Care and Programs	588,616	66,135	40,629	695,380		695,380	6,910	702,290		16
	C. General Administration										
17	Administrative	55,838		32,500	88,338		88,338	(20,198)	68,140		17
18	Directors Fees										18
19	Professional Services			7,226	7,226		7,226	6,688	13,914		19
20	Dues, Fees, Subscriptions & Promotions			10,366	10,366		10,366	443	10,809		20
21	Clerical & General Office Expenses	29,300	5,322	9,420	44,042		44,042	22,503	66,545		21
22	Employee Benefits & Payroll Taxes			153,320	153,320		153,320	4,159	157,479		22
23	Inservice Training & Education							148	148		23
24	Travel and Seminar							427	427		24
25	Other Admin. Staff Transportation			10,607	10,607		10,607	1,745	12,352		25
26	Insurance-Prop.Liab.Malpractice			12,151	12,151		12,151	912	13,063		26
27	Other (specify):* Home Office Benefits							4,452	4,452		27
28	TOTAL General Administration	85,138	5,322	235,590	326,050		326,050	21,279	347,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	886,513	190,402	327,090	1,404,005		1,404,005	24,550	1,428,555		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Countryview Care Center-Macomb

#0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			73,763	73,763		73,763	5,339	79,102			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,058	128,058		128,058	13,481	141,539			32
33	Real Estate Taxes			38,800	38,800		38,800	1,598	40,398			33
34	Rent-Facility & Grounds							728	728			34
35	Rent-Equipment & Vehicles			5,941	5,941		5,941	475	6,416			35
36	Other (specify):*											36
37	TOTAL Ownership			246,562	246,562		246,562	21,621	268,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		322		322		322		322			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,945	33,945		33,945		33,945			42
43	Other (specify):* Nonallowable Cost			75,021	75,021		75,021	(75,021)				43
44	TOTAL Special Cost Centers		322	108,966	109,288		109,288	(75,021)	34,267			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	886,513	190,724	682,618	1,759,855		1,759,855	(28,850)	1,731,005			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,540)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,335)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50)	30		9
10	Interest and Other Investment Income	(3,137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(419)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,202)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(33,489)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,172)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,322	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,322		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (28,850)		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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Care Center-Macomb

ID# 0047431

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (2,529)	43	1
2	Nonallowable special events	(4,176)	43	2
3	Nonallowable advertising-promotion	(4,513)	43	3
4	Labs - Part A	(13,805)	43	4
5	X-Rays - Part A	(1,106)	43	5
6	Misc Part A Procedures	(935)	43	6
7	Misc Revenue	(25)	21	7
8	Misc Revenue	(403)	21	8
9	Chamber of Commerce Dues	(350)	20	9
10	Vending Revenue	(861)	2	10
11	Nonallowable Home Office Architect Fees	(359)	19	11
12	Nonallowable Travel	(4,426)	24	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	(33,489)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,151	0	457	0	0	0	0	0	0	0	1,608	1
2	Food Purchase	(6,401)	57	0	4	0	0	0	0	0	0	0	(6,340)	2
3	Housekeeping	0	51	0	1	0	0	0	0	0	0	0	52	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	213	0	0	0	0	0	0	0	0	0	213	5
6	Maintenance	0	2,926	0	1,060	0	0	0	0	0	0	0	3,986	6
7	Other (specify):*	0	461	0	540	0	0	0	0	0	0	0	1,001	7
8	TOTAL General Services	(6,401)	4,859	0	2,062	0	520	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	4,160	0	806	0	0	0	0	0	0	0	4,966	10
10a	Therapy	0	382	0	0	0	0	0	0	0	0	0	382	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	1,286	0	276	0	0	0	0	0	0	0	1,562	15
16	TOTAL Health Care and Programs	0	5,828	0	1,082	0	6,910	16						
	C. General Administration													
17	Administrative	0	(21,160)	0	961	0	0	0	0	0	0	0	(20,199)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(359)	4,967	0	2,080	0	0	0	0	0	0	0	6,688	19
20	Fees, Subscriptions & Promotions	(350)	487	0	306	0	0	0	0	0	0	0	443	20
21	Clerical & General Office Expenses	(428)	0	18,280	4,650	0	0	0	0	0	0	0	22,502	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	148	0	0	0	0	0	0	0	0	148	23
24	Travel and Seminar	(4,426)	0	4,426	427	0	0	0	0	0	0	0	427	24
25	Other Admin. Staff Transportation	0	0	1,177	568	0	0	0	0	0	0	0	1,745	25
26	Insurance-Prop.Liab.Malpractice	0	0	872	41	0	0	0	0	0	0	0	913	26
27	Other (specify):*	0	0	3,231	1,221	0	0	0	0	0	0	0	4,452	27
28	TOTAL General Administration	(5,563)	(15,706)	28,134	10,254	0	17,119	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,964)	(5,019)	28,134	13,398	0	24,549	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(50)	0	4,507	882	0	0	0	0	0	0	0	5,339	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,137)	0	2,504	14,114	0	0	0	0	0	0	0	13,481	32
33	Real Estate Taxes	0	0	529	1,070	0	0	0	0	0	0	0	1,599	33
34	Rent-Facility & Grounds	0	0	512	216	0	0	0	0	0	0	0	728	34
35	Rent-Equipment & Vehicles	0	0	268	207	0	0	0	0	0	0	0	475	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,187)	0	8,320	16,489	0	21,622	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):*	(75,021)	0	0	0	0	0	0	0	0	0	0	(75,021)	43
44	TOTAL Special Cost Centers	(75,021)	0	0	0	0	0	0	0	0	0	0	(75,021)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(90,172)	(5,019)	36,454	29,887	0	(28,850)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,151	\$ 1,151	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	57	57	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	51	51	3
4								4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	213	213	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,926	2,926	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	461	461	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,160	4,160	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	382	382	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,286	1,286	10
11	V	17 Administrative	32,500	Petersen Health Care, Inc.	100.00%	11,340	(21,160)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,967	4,967	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	487	487	13
14	Total		\$ 32,500			\$ 27,481	\$ * (5,019)	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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 18,280	\$	18,280	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	148		148	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4,426		4,426	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,177		1,177	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	872		872	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,231		3,231	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,507		4,507	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,504		2,504	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	529		529	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	512		512	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	268		268	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		\$			\$ 36,454	\$ *	36,454	39

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

Facility Name & ID Number Countryview Care Center-Macomb# 0047431Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 457	\$	457	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	4		4	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	1		1	17
18	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,060		1,060	18
19	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	540		540	19
20	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	806		806	20
21	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	276		276	21
22	V	17 Administrative		Petersen Health Care, Inc.	100.00%	961		961	22
23	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,080		2,080	23
24	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	306		306	24
25	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	4,650		4,650	25
26	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	427		427	26
27	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	568		568	27
28	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	41		41	28
29	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,221		1,221	29
30	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	882		882	30
31	V	32 Interest		Petersen Health Care, Inc.	100.00%	14,114		14,114	31
32	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,070		1,070	32
33	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	216		216	33
34	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	207		207	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 29,887	\$ *	29,887	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Care Center-Macomb # 0047431 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.71	1.42	Salary	\$ 11,341	L17,C7	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	\$ 11,341		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	16,181	\$ 1,151	1
2	2	Food	Patient Days	1,141,463	56	3,989	0	16,181	57	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	0	16,181	51	3
										4
5	5	Utilities	Patient Days	1,141,463	56	15,054	0	16,181	213	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	16,181	2,926	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	0	16,181	461	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	16,181	4,160	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	0	16,181	382	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	0	16,181	1,286	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	16,181	11,341	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	16,181	4,967	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	0	16,181	487	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	16,181	18,281	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	0	16,181	148	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	0	16,181	4,426	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	0	16,181	1,177	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	0	16,181	871	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	0	16,181	3,231	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	0	16,181	4,507	20
21	32	Interest	Patient Days	1,141,463	56	176,614	0	16,181	2,504	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	0	16,181	528	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	0	16,181	512	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	0	16,181	268	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 63,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	427,669	46	\$ 12,081	\$ 11,958	16,181	\$ 457	1
2	2	Food	Patient Days	427,669	46	93		16,181	4	2
3	3	Housekeeping	Patient Days	427,669	46	28		16,181	1	3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	16,181	1,060	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		16,181	540	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	16,181	806	8
9										9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		16,181	276	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	16,181	961	11
12	19	Professional Services	Patient Days	427,669	46	54,971		16,181	2,080	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		16,181	306	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	16,181	4,650	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280		16,181	427	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		16,181	568	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		16,181	41	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		16,181	1,221	19
20	30	Depreciation	Patient Days	427,669	46	23,301		16,181	882	20
21	32	Interest	Patient Days	427,669	46	373,049		16,181	14,114	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282		16,181	1,070	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		16,181	216	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		16,181	207	24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 29,887	25

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Care Center-Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0047431

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-400-806-00</u>	<u>Nursing Home</u>	\$ <u>38,714.00</u>	\$ <u>38,714.00</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,598.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,714.00</u>	\$ <u>40,312.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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: 12,290 B. General Construction Type: Exterior Brick Frame Wood 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).

N/A

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

1. Total Amount Incurred: 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>103,237</u>	<u>2005</u>	<u>\$ 58,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	103,237		\$ 58,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	62	2005	1970	\$ 1,057,000	\$	25	\$ 42,280	\$ 42,280	\$ 63,420
5									
6									
7	06 Home Office								
8	Allocation	2006		9,650			422	422	422
Improvement Type**									
9	Land Improvement	2006		15,000		15	1,000	1,000	1,500
10									
11	Land Improvement Booked				1,000			(1,000)	
12	Building Booked				42,310			(42,310)	
13	Building Improvement Booked								
14									
15	2006 Home Office allocation - Land & Land Improvements		2006	558			52	52	52
16	2006 Home Office allocation - Buildings Improvements		2006	16			1	1	1
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		1,082,224	43,310		43,755	445	65,395	

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 Depreciation-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	\$ 204,968	\$ 30,453	\$ 30,173	\$ (280)	3-7 Years	\$ 45,259	71
72	Current Year Purchases	2,250		261	261	3-5 Years	261	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,913	4,913			74
75	TOTALS	\$ 207,218	\$ 30,453	\$ 35,347	\$ 4,894		\$ 45,520	75

D. Vehicle Depreciation (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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,347,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 73,763	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,102	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,339	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 110,915	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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		Home Office Allocation			728			6
7	TOTAL				\$ 728			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 6,416 Description: Copier \$2,872; Dishwasher \$767; Home Office Allocation \$475; Nursing Equip \$2,302

(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			\$	\$	17
18			N/A		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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1),(3)	1455	hrs	\$ 29,684	163	\$ 12,354	\$	1,618	\$ 42,038	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		53	4,581		53	4,581	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A (1),(2),(3),(7)	52	hrs	2,654	140	10,843	382	192	13,879	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescripts				322		322	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 32,338	356	\$ 27,778	\$ 704	1,863	\$ 60,820	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

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 675	\$ 675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u>)	341,872	341,872	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,046	4,046	7
8	Accounts Receivable (owners or related parties)	4,275	4,275	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 350,868	\$ 350,868	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,130,500	1,125,150	14
15	Leasehold Improvements, at Historical Cost		15,574	15
16	Equipment, at Historical Cost	207,218	207,218	16
17	Accumulated Depreciation (book methods)	(89,610)	(110,915)	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)	\$ 1,248,108	\$ 1,237,027	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,598,976	\$ 1,587,895	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 382,195	\$ 382,195	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,423	17,423	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,627	4,627	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,800	38,800	32
33	Accrued Interest Payable	13,659	13,659	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	9,505	9,505	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 466,209	\$ 466,209	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	209,616	209,616	40
41	Bonds Payable	1,103,651	1,103,651	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)	\$ 1,313,267	\$ 1,313,267	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,779,476	\$ 1,779,476	46
47	TOTAL EQUITY (page 18, line 24)	\$ (180,500)	\$ (191,581)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,598,976	\$ 1,587,895	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (45,327)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (45,327)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(135,174)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Rounding	1	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (135,173)	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)	\$ (180,500)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,349,661	1
2	Discounts and Allowances for all Levels	72,084	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,421,745	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,568	6
7	Oxygen	733	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 123,301	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	25	13
14	Non-Patient Meals	5,540	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,177	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,491	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75,233	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,137	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Rev	1,264	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,264	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,624,680	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	382,575	31
32	Health Care	695,380	32
33	General Administration	326,050	33
	B. Capital Expense		
34	Ownership	246,562	34
	C. Ancillary Expense		
35	Special Cost Centers	75,343	35
36	Provider Participation Fee	33,945	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,759,855	40
41	Income before Income Taxes (line 30 minus line 40)**	(135,174)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (135,174)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash-basis taxpayer

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

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

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,072	2,072	\$ 45,322	\$ 21.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,988	3,063	59,936	19.57	3
4	Licensed Practical Nurses	7,254	7,577	118,833	15.68	4
5	CNAs & Orderlies	24,550	24,896	233,565	9.38	5
6	CNA Trainees					6
7	Licensed Therapist	1,507	1,507	32,338	21.46	7
8	Rehab/Therapy Aides	1,213	1,213	17,290	14.25	8
9	Activity Director	1,915	1,915	19,029	9.94	9
10	Activity Assistants			243		10
11	Social Service Workers	2,459	2,483	28,705	11.56	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,925	13.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,760	9,037	66,174	7.32	15
16	Dishwashers					16
17	Maintenance Workers	1,607	1,625	17,161	10.56	17
18	Housekeepers	6,754	6,942	57,977	8.35	18
19	Laundry	5,064	5,200	42,522	8.18	19
20	Administrator	2,080	2,080	55,838	26.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,944	1,944	29,300	15.07	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>CPC</u>	2,080	2,080	33,355	16.04	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	74,327	75,714	\$ 886,513 *	\$ 11.71	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 4,749	1,3	35
36	Medical Director	Monthly	5,269	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	881	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Rehab Consultant</u>	14	692	10,3	47
48					48
49	TOTAL (lines 35 - 48)	110	\$ 11,591		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Care Center-Macomb

0047431

Report Period Beginning:

01/01/06

Ending:

12/31/06

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,074 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,945
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 4,159 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,540
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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