

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0046078

Facility Name: Countryview Terrace

Address: P.O. Box 116 Louisville 62858
 Number City Zip Code

County: Clay

Telephone Number: (618) 686-4542 Fax # (618) 686-2179

HFS ID Number: 3713463060001

Date of Initial License for Current Owners: 02/01/96

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: Christine A. Hanover Telephone Number: (312) 634-4581
 Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) _____
	(Title) _____
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>
	(Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>
	(Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518
	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace

0046078 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,632			5,632	13
14	TOTALS	5,632			5,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.44%

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 2/10/96

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

YES Date 2/10/96 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Countryview Terrace

0046078

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	23,832	2,312		26,144		26,144	401	26,545		1
2	Food Purchase		16,502		16,502		16,502	20	16,522		2
3	Housekeeping		2,460		2,460		2,460	18	2,478		3
4	Laundry		1,191		1,191		1,191		1,191		4
5	Heat and Other Utilities			12,326	12,326		12,326	74	12,400		5
6	Maintenance	1,053	11,931	1,080	14,064		14,064	1,018	15,082		6
7	Other (specify):* Home office benefits							160	160		7
8	TOTAL General Services	24,885	34,396	13,406	72,687		72,687	1,691	74,378		8
	B. Health Care and Programs										
9	Medical Director			1,355	1,355		1,355		1,355		9
10	Nursing and Medical Records	107,650	5,590	4,380	117,620		117,620	1,448	119,068		10
10a	Therapy			1,089	1,089		1,089	133	1,222		10a
11	Activities		368	389	757		757		757		11
12	Social Services	20,020			20,020		20,020		20,020		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home office benefits							1,125	1,125		15
16	TOTAL Health Care and Programs	127,670	5,958	7,213	140,841		140,841	2,706	143,547		16
	C. General Administration										
17	Administrative	34,920			34,920		34,920	3,947	38,867		17
18	Directors Fees										18
19	Professional Services			7,503	7,503		7,503	1,604	9,107		19
20	Dues, Fees, Subscriptions & Promotions			281	281		281	169	450		20
21	Clerical & General Office Expenses		1,927	4,992	6,919		6,919	3,740	10,659		21
22	Employee Benefits & Payroll Taxes			26,006	26,006		26,006		26,006		22
23	Inservice Training & Education			148	148		148	51	199		23
24	Travel and Seminar							1,541	1,541		24
25	Other Admin. Staff Transportation			8,698	8,698		8,698	(310)	8,388		25
26	Insurance-Prop.Liab.Malpractice			20,737	20,737		20,737	303	21,040		26
27	Other (specify):* Home office benefits							448	448		27
28	TOTAL General Administration	34,920	1,927	68,365	105,212		105,212	11,493	116,705		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	187,475	42,281	88,984	318,740		318,740	15,890	334,630		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 Terrace

#0046078

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			18,348	18,348		18,348	4,894	23,242			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,850	35,850		35,850	871	36,721			32
33	Real Estate Taxes			5,502	5,502		5,502	184	5,686			33
34	Rent-Facility & Grounds							178	178			34
35	Rent-Equipment & Vehicles			225	225		225	93	318			35
36	Other (specify):*											36
37	TOTAL Ownership			59,925	59,925		59,925	6,220	66,145			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			789	789		789		789			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,584	28,584		28,584		28,584			42
43	Other (specify):* Nonallowable Cost			1,310	1,310		1,310	(1,310)				43
44	TOTAL Special Cost Centers			30,683	30,683		30,683	(1,310)	29,373			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	187,475	42,281	179,592	409,348		409,348	20,800	430,148			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

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace

0046078

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				4
5	Telephone, TV & Radio in Resident Rooms	(424)	L43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,325	L30		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	(37)	L43		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				24
25	Fund Raising, Advertising and Promotional	(203)	L43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(4,114)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,453)		\$	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)	22,253	var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,253		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ 20,800		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	

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Countryview Terrace

ID# 0046078

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PET EXPENSE	\$ (71)	43	1
2	SPECIAL EVENTS	(575)	43	2
3	OFFSET MISC INCOME	(2,623)	27	3
4	OFFSET TRAVEL INCOME	(720)	27	4
5	Nonallowable home office architect fees	(125)	19	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	(4,114)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Terrace# 0046078

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	401	0	0	0	0	0	0	0	0	0	401	1
2	Food Purchase	0	20	0	0	0	0	0	0	0	0	0	20	2
3	Housekeeping	0	18	0	0	0	0	0	0	0	0	0	18	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	74	0	0	0	0	0	0	0	0	0	74	5
6	Maintenance	0	1,018	0	0	0	0	0	0	0	0	0	1,018	6
7	Other (specify):*	0	160	0	0	0	0	0	0	0	0	0	160	7
8	TOTAL General Services	0	1,691	0	0	0	0	0	0	0	0	0	1,691	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	1,448	0	0	0	0	0	0	0	0	0	1,448	10
10a	Therapy	0	133	0	0	0	0	0	0	0	0	0	133	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	448	0	0	0	0	0	0	0	0	0	448	15
16	TOTAL Health Care and Programs	0	2,029	0	0	0	0	0	0	0	0	0	2,029	16
	C. General Administration													
17	Administrative	0	3,947	0	0	0	0	0	0	0	0	0	3,947	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(125)	1,729	0	0	0	0	0	0	0	0	0	1,604	19
20	Fees, Subscriptions & Promotions	0	169	0	0	0	0	0	0	0	0	0	169	20
21	Clerical & General Office Expenses	0	0	6,363	0	0	0	0	0	0	0	0	6,363	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	51	0	0	0	0	0	0	0	0	51	23
24	Travel and Seminar	0	0	1,541	0	0	0	0	0	0	0	0	1,541	24
25	Other Admin. Staff Transportation	0	0	410	0	0	0	0	0	0	0	0	410	25
26	Insurance-Prop.Liab.Malpractice	0	0	303	0	0	0	0	0	0	0	0	303	26
27	Other (specify):*	(3,343)	0	1,125	0	0	0	0	0	0	0	0	(2,218)	27
28	TOTAL General Administration	(3,468)	5,845	9,793	0	0	0	0	0	0	0	0	12,170	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,468)	9,565	9,793	0	0	0	0	0	0	0	0	15,890	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Terrace # 0046078 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	0	0	1,569	0	0	0	0	0	0	0	0	1,569	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	871	0	0	0	0	0	0	0	0	871	32
33	Real Estate Taxes	0	0	184	0	0	0	0	0	0	0	0	184	33
34	Rent-Facility & Grounds	0	0	178	0	0	0	0	0	0	0	0	178	34
35	Rent-Equipment & Vehicles	0	0	93	0	0	0	0	0	0	0	0	93	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	2,895	0	2,895	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):*	(646)	0	0	0	0	0	0	0	0	0	0	(646)	43
44	TOTAL Special Cost Centers	(646)	0	0	0	0	0	0	0	0	0	0	(646)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,114)	9,565	12,688	0	18,139	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	100%	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%	\$ 401	\$ 401	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	20	20	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	74	74	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,018	1,018	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	160	160	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,448	1,448	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	133	133	9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	448	448	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	3,947	3,947	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,729	1,729	12	
13	V	20 Due, Fees, Su bs & Promos		Petersen Health Care, Inc.	100.00%	169	169	13	
14	Total		\$			\$ 9,565	\$ *	9,565	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 6,363	\$ 6,363	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	51	51	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,541	1,541	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	410	410	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	303	303	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,125	1,125	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,569	1,569	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	871	871	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	184	184	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	178	178	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	93	93	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		\$			\$ 12,688	\$ * 12,688	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0046078 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 Sched 7A	0.25	0.49	Salary	\$ 3,947	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	\$ 3,947		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

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace

0046078

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	56	\$ 81,179	\$ 80,967	5,632	\$ 401	1
2	2	Food	Patient Days	56	3,989		5,632	20	2
3	3	Housekeeping	Patient Days	56	3,589		5,632	18	3
4	4	Laundry	Patient Days	56	0		5,632	0	4
5	5	Utilities	Patient Days	56	15,054		5,632	74	5
6	6	Maintenance	Patient Days	56	206,416	110,513	5,632	1,018	6
7	7	Mgmt. Allocation of Benefits	Patient Days	56	32,526		5,632	160	7
8	10	Nursing and Medical Records	Patient Days	56	293,462	289,197	5,632	1,448	8
9	10A	Therapy	Patient Days	56	26,945		5,632	133	9
10	15	Mgmt. Allocation of Benefits	Patient Days	56	90,724		5,632	448	10
11	17	Administrative	Patient Days	56	800,000	800,000	5,632	3,947	11
12	19	Professional Services	Patient Days	56	350,361		5,632	1,729	12
13	20	Due, Fees, Subs & Promos	Patient Days	56	34,325		5,632	169	13
14	21	Clerical & General Office	Patient Days	56	1,289,623	954,322	5,632	6,363	14
15	23	Inservice Training & Education	Patient Days	56	10,426		5,632	51	15
16	24	Travel and Seminar	Patient Days	56	312,259		5,632	1,541	16
17	25	Other Admin. Staff Transport	Patient Days	56	83,062		5,632	410	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	56	61,457		5,632	303	18
19	27	Mgmt Allocation of Benefits	Patient Days	56	227,912		5,632	1,125	19
20	30	Depreciation	Patient Days	56	317,964		5,632	1,569	20
21	32	Interest	Patient Days	56	176,614		5,632	871	21
22	33	Real Estate Taxes	Patient Days	56	37,282		5,632	184	22
23	34	Rent - Facility & Grounds	Patient Days	56	36,133		5,632	178	23
24	35	Rent - Equipment & Vehicles	Patient Days	56	18,933		5,632	93	24
25	TOTALS				\$ 4,510,235	\$ 2,234,999		\$ 22,253	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/06 Ending: 12/31/06

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										
										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	LaSalle Bank		X	Mortgage	649 plus int.	08/31/02	\$ 479,263	\$ 445,520	8/31/07	varies	\$ 33,466	1							
2												2							
3							Allocated from Home Office				871	3							
4												4							
5												5							
Working Capital																			
6	LaSalle Bank		X	Working Capital	Interest only	08/31/02	54,387		LOC	varies	2,384	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 533,650	\$ 445,520			\$ 36,721	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 533,650	\$ 445,520			\$ 36,721	15							

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

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

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

Facility Name & ID Number **Countryview Terrace**

0046078 Report Period Beginning: **01/01/06** Ending: **12/31/06**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$	4,463
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2005	\$	4,965
3. Under or (over) accrual (line 2 minus line 1).		\$	502
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	5,000
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			184
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	5,686
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	4,508	8
	2002	4,510	9
	2003	4,596	10
	2004	4,932	11
	2005	4,965	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005	\$
	14	PLUS APPEAL COST FROM LINE 5	\$
	15	LESS REFUND FROM LINE 6	\$
	16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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 Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046078

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>02-15-100-030</u>	<u>Nursing Home</u>	\$ <u>4,965.18</u>	\$ <u>4,965.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,965.18</u>	\$ <u>4,965.18</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.

Facility Name & ID Number Countryview Terrace# 0046078

Report Period Beginning:

01/01/06

Ending:

12/31/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. 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/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>402,930</u>	<u>1996</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	402,930		\$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	16		1996	1976	\$ 579,889	\$	35	\$ 16,568	\$ 16,568	\$ 182,122	4
5											5
6	Allocation				3,359			147	147	147	6
7	From Home										7
8	Office										8
	Improvement Type**										
9	Land Survey		1996		1,700		20	85	85	907	9
10	Curtains		1996		307		20	15	15	158	10
11	Pump Repairs		1996		1,163		20	58	58	624	11
12	Repiping Water Heater		1996		1,681		20	84	84	889	12
13	Fence		1997		2,469		20	123	123	1,138	13
14	Plumbing		1997		1,234		20	62	62	599	14
15	Handicapped Showers & Ramp		1998		1,962		20	98	98	833	15
16	Landscaping		2000		4,289		20	214	214	1,391	16
17	Drainage and Sidewalk		2001		2,557		20	128	128	705	17
18	Roof		2001		8,701		20	435	435	2,393	18
19	Water Supply		2002		2,413		20	121	121	544	19
20	Roof		2004		900		20	45	45	113	20
21	Bathroom Sinks and Showers		2004		12,800		20	640	640	1,600	21
22											22
23											23
24	Land Improvement Booked					149			(149)		24
25	Building Booked					14,869			(14,869)		25
26	Building Improvement Booked					1,005			(1,005)		26
27											27
28											28
29	2006 Home Office Allocation - Land & Land Improvements		2006		194			18	18	18	29
30	2006 Home Office Allocation - Building Improvements		2006		5						30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)		\$ 625,623	\$ 16,023		\$ 18,842	\$ 2,819	\$ 194,182	70

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	\$ 43,492	\$ 1,562	\$ 2,968	\$ 1,406	10	\$ 38,499	71
72	Current Year Purchases	563		28	28	10	28	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			1,404	1,404			74
75	TOTALS	\$ 44,055	\$ 1,562	\$ 4,400	\$ 2,838		\$ 38,527	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	Resident Use	1995 Dodge Maxivan	1999	\$ 9,986	\$ 763	\$	\$ (763)	5	\$ 9,986	76
77										77
78										78
79										79
80	TOTALS			\$ 9,986	\$ 763	\$	\$ (763)		\$ 9,986	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)	\$ 689,664	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,348	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,242	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,894	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 242,695	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		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: NA

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		<u>Allocated from home office</u>			<u>178</u>			6
7	TOTAL				\$ <u>178</u>			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 NA
by the length of the lease NA.

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: \$ 318 Description: Nurse Equipt \$225, Home ofc. \$93

(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			\$ <u>NA</u>	\$	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. /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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	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	10A3	hrs	\$	6	\$ 486	\$	6	\$ 486	1
2	Licensed Speech and Language Development Therapist	10A3	hrs		7	603		7	603	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		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)			9	789		9	789	12
13	Other (specify):									13
14	TOTAL			\$	22	\$ 1,878	\$	22	\$ 1,878	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

See Accountants' Compilation Report

STATE OF ILLINOIS

Facility Name & ID Number Countryview Terrace

0046078

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 281,584	\$ 281,584	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	146,822	146,822	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136	136	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,131	116,131	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 544,673	\$ 544,673	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	613,818	625,623	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	54,041	54,041	16
17	Accumulated Depreciation (book methods)	(220,608)	(242,695)	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)	\$ 461,420	\$ 446,969	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,006,093	\$ 991,642	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 52,696	\$ 52,696	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,171	8,171	30
31	Accrued Taxes Payable (excluding real estate taxes)	439	439	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,000	5,000	32
33	Accrued Interest Payable	2,368	2,368	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued expenses</u>	2,158	2,158	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 70,832	\$ 70,832	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	445,520	445,520	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 445,520	\$ 445,520	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 516,352	\$ 516,352	46
47	TOTAL EQUITY(page 18, line 24)	\$ 489,741	\$ 475,290	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,006,093	\$ 991,642	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 365,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 365,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,777	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) Rounding	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 123,781	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)	\$ 489,741	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 529,782	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 529,782	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation</u>	720	28
28a	<u>Miscellaneous</u>	2,623	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,343	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 533,125	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	72,687	31
32	Health Care	140,841	32
33	General Administration	105,212	33
B. Capital Expense			
34	Ownership	59,925	34
C. Ancillary Expense			
35	Special Cost Centers	2,099	35
36	Provider Participation Fee	28,584	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 409,348	40
41	Income before Income Taxes (line 30 minus line 40)**	123,777	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 123,777	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 Terrace

0046078

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				1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	542	542	3,929	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	1,906	1,906	20,020	11
12	Dietician				12
13	Food Service Supervisor	1,997	1,997	23,832	13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	117	117	1,053	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	2,080	2,080	34,920	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care Daily Living Aides	13,166	13,166	103,721	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	19,807	19,807	\$ 187,475 *	\$ 9.46 34

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

** See instructions.

See Accountants' Compilation Report

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	monthly	1,355	9,3 36
37	Medical Records Consultant			37
38	Nurse Consultant	104	2,800	10,3 38
39	Pharmacist Consultant			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) Psychologist	6 visits	1,420	10,3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	104	\$ 5,575	49

C. CONTRACT NURSES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace

0046078

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? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 212 Line 10,2
- (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. \$ 28,584
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- 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? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintain
- 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? N/A**
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 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.

SEE ACCOUNTANTS' COMPILATION REPORT