



Facility Name & ID Number Countryview Care Center-Macomb

# 0047431 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			951	951	8
9	SNF/PED					9
10	ICF	13,208	1,844		15,052	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,208	1,844	951	16,003	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.72%

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

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

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

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 951

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Countryview Care Center-Maccomb # 0047431 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	105,457	10,713	1,729	117,899		117,899	3,222	121,121		1
2	Food Purchase		98,728		98,728		98,728	(5,943)	92,785		2
3	Housekeeping	67,276	6,406		73,682		73,682	15	73,697		3
4	Laundry	50,215	10,845		61,060		61,060	1	61,061		4
5	Heat and Other Utilities			52,579	52,579		52,579	229	52,808		5
6	Maintenance	18,223	10,829	8,386	37,438		37,438	1,878	39,316		6
7	Other (specify):* Home Off. Ben. All.							2,182	2,182		7
8	<b>TOTAL General Services</b>	241,171	137,521	62,694	441,386		441,386	1,584	442,970		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	516,812	40,663	40,102	597,577		597,577	5,754	603,331		10
10a	Therapy		139	89,193	89,332		89,332		89,332		10a
11	Activities	19,910	2,341	1,117	23,368		23,368	(786)	22,582		11
12	Social Services	22,104			22,104		22,104		22,104		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,628	2,628		15
16	<b>TOTAL Health Care and Programs</b>	558,826	43,143	135,212	737,181		737,181	7,596	744,777		16
	<b>C. General Administration</b>										
17	Administrative	58,534		50,000	108,534		108,534	(32,339)	76,195		17
18	Directors Fees										18
19	Professional Services			15,313	15,313		15,313	4,928	20,241		19
20	Dues, Fees, Subscriptions & Promotions			7,292	7,292		7,292	216	7,508		20
21	Clerical & General Office Expenses	32,235	8,705	8,440	49,380		49,380	24,571	73,951		21
22	Employee Benefits & Payroll Taxes			178,691	178,691		178,691		178,691		22
23	Inservice Training & Education			236	236		236	261	497		23
24	Travel and Seminar			60	60		60	415	475		24
25	Other Admin. Staff Transportation			3,911	3,911		3,911	2,707	6,618		25
26	Insurance-Prop.Liab.Malpractice			10,764	10,764		10,764	613	11,377		26
27	Other (specify):* Home Off. Ben. All.							12,906	12,906		27
28	<b>TOTAL General Administration</b>	90,769	8,705	274,707	374,181		374,181	14,278	388,459		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	890,766	189,369	472,613	1,552,748		1,552,748	23,458	1,576,206		29

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

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

Facility Name &amp; ID Number

Countryview Care Center-Macomb

#0047431

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			76,192	76,192		76,192	2,428	78,620			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,769	68,769		68,769	36,687	105,456			32
33	Real Estate Taxes			39,845	39,845		39,845	524	40,369			33
34	Rent-Facility & Grounds							32	32			34
35	Rent-Equipment & Vehicles			10,411	10,411		10,411	422	10,833			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			195,217	195,217		195,217	40,093	235,310			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,778		15,778		15,778		15,778			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):* Non-allowable Cost	20,630	4,454	92,658	117,742		117,742	(117,742)				43
44	<b>TOTAL Special Cost Centers</b>	20,630	20,232	126,603	167,465		167,465	(117,742)	49,723			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	911,396	209,601	794,433	1,915,430		1,915,430	(54,191)	1,861,239			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.

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,989)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,310)	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	(69)	30		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	(864)	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	(18,038)	43		18
19	Entertainment				19
20	Contributions	(80)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,690)	43		24
25	Fund Raising, Advertising and Promotional	(30,228)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(10,028)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (125,296)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	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)	71,105	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 71,105		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (54,191)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Countryview Care Center-Macomb

ID# 0047431

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,758)	43	1
2	X-Rays-Part A	(573)	43	2
3	Resident Flower	(407)	43	3
4	Disallowed Special Events	(794)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(290)	21	5
6	Offset Chamber of Commerce Dues	(420)	20	6
7	Offset Transportation Revenue	(786)	11	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
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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	<b>Total</b>	(10,028)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Countryview Care Center-Macomb

# 0047431

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	1,339	0	1,883	0	0	0	0	0	0	0	3,222	1
2	Food Purchase	(5,989)	46	0	0	0	0	0	0	0	0	0	(5,943)	2
3	Housekeeping	0	15	0	0	0	0	0	0	0	0	0	15	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	229	0	0	0	0	0	0	0	0	0	229	5
6	Maintenance	0	1,865	0	13	0	0	0	0	0	0	0	1,878	6
7	Other (specify):*	0	611	0	1,571	0	0	0	0	0	0	0	2,182	7
8	<b>TOTAL General Services</b>	<b>(5,989)</b>	<b>4,106</b>	<b>0</b>	<b>3,467</b>	<b>0</b>	<b>1,584</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,541	0	2,213	0	0	0	0	0	0	0	5,754	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(786)	0	0	0	0	0	0	0	0	0	0	(786)	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	787	0	1,841	0	0	0	0	0	0	0	2,628	15
16	<b>TOTAL Health Care and Programs</b>	<b>(786)</b>	<b>4,328</b>	<b>0</b>	<b>4,054</b>	<b>0</b>	<b>7,596</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(40,031)	0	7,692	0	0	0	0	0	0	0	(32,339)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,706	0	2,222	0	0	0	0	0	0	0	4,928	19
20	Fees, Subscriptions & Promotions	(420)	0	586	50	0	0	0	0	0	0	0	216	20
21	Clerical & General Office Expenses	(290)	0	22,699	2,162	0	0	0	0	0	0	0	24,571	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	261	0	0	0	0	0	0	0	0	261	23
24	Travel and Seminar	0	0	415	0	0	0	0	0	0	0	0	415	24
25	Other Admin. Staff Transportation	0	0	1,505	1,202	0	0	0	0	0	0	0	2,707	25
26	Insurance-Prop.Liab.Malpractice	0	0	613	0	0	0	0	0	0	0	0	613	26
27	Other (specify):*	0	0	6,490	6,416	0	0	0	0	0	0	0	12,906	27
28	<b>TOTAL General Administration</b>	<b>(710)</b>	<b>(37,325)</b>	<b>32,569</b>	<b>19,744</b>	<b>0</b>	<b>14,278</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(7,485)</b>	<b>(28,891)</b>	<b>32,569</b>	<b>27,265</b>	<b>0</b>	<b>23,458</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Care Center-Macomb# 0047431

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(69)	0	1,589	908	0	0	0	0	0	0	0	2,428	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,763	33,924	0	0	0	0	0	0	0	36,687	32
33	Real Estate Taxes	0	0	524	0	0	0	0	0	0	0	0	524	33
34	Rent-Facility & Grounds	0	0	32	0	0	0	0	0	0	0	0	32	34
35	Rent-Equipment & Vehicles	0	0	422	0	0	0	0	0	0	0	0	422	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(69)</b>	<b>0</b>	<b>5,330</b>	<b>34,832</b>	<b>0</b>	<b>40,093</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(117,742)	0	0	0	0	0	0	0	0	0	0	(117,742)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(117,742)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(117,742)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(125,296)</b>	<b>(28,891)</b>	<b>37,899</b>	<b>62,097</b>	<b>0</b>	<b>(54,191)</b>	<b>45</b>						

**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 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,339	\$ 1,339	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	46	46	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	15	15	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	229	229	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,865	1,865	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	611	611	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,541	3,541	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	787	787	10
11	V	17 Administrative	50,000	Petersen Health Care, Inc.	100.00%	9,969	(40,031)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,706	2,706	12
13	V							13
14	Total		\$ 50,000			\$ 21,109	\$ * (28,891)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 586	\$	586	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	22,699		22,699	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	261		261	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	415		415	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,505		1,505	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	613		613	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,490		6,490	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,589		1,589	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,763		2,763	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	524		524	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	32		32	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	422		422	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	<b>Total</b>		\$			\$ 37,899	\$ *	37,899	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 1,883	\$	1,883	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	13		13	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,571		1,571	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,213		2,213	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,841		1,841	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	7,692		7,692	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,222		2,222	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	50		50	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,162		2,162	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		0	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	1,202		1,202	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	6,416		6,416	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	908		908	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	33,924		33,924	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 62,097	\$ *	62,097	39

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

Facility Name & ID Number Countryview Care Center-Macomb # 0047431 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## 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	0.65	1.19	Salary	\$ 9,969	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	\$ 9,969		13

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

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

Facility Name & ID Number Countryview Care Center-Macomb# 0047431

Report Period Beginning:

01/01/2007Ending: 2/31/2007

## 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 W. 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	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	16,003	\$ 1,339	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	16,003	46	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	16,003	15	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	16,003	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	16,003	229	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	16,003	1,865	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	16,003	611	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	16,003	3,541	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	16,003	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	16,003	787	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	16,003	9,969	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	16,003	2,706	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	16,003	586	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	16,003	22,699	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	16,003	261	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	16,003	415	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	16,003	1,505	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	16,003	613	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	16,003	6,490	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	16,003	1,589	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	16,003	2,763	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	16,003	524	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	16,003	32	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	16,003	422	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 59,008	25

Facility Name & ID Number Countryview Care Center-Macomb# 0047431 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

## 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 Operations, LLC  
 Street Address 830 W. 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	Resident Days	440,525	23	\$ 51,832	\$ 51,832	16,003	\$ 1,883	1
2	2	Food	Resident Days	440,525	23			16,003		2
3	3	Housekeeping	Resident Days	440,525	23			16,003		3
4	4	Laundry	Resident Days	440,525	23			16,003		4
5	5	Utilities	Resident Days	440,525	23			16,003		5
6	6	Maintenance	Resident Days	440,525	23	358		16,003	13	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		16,003	1,571	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	16,003	2,213	8
9	10A	Therapy	Resident Days	440,525	23			16,003		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		16,003	1,841	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	16,003	7,692	11
12	19	Professional Services	Resident Days	440,525	23	61,162		16,003	2,222	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		16,003	50	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		16,003	2,162	14
15	23	Inservice Training & Education	Resident Days	440,525	23			16,003		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		16,003		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		16,003	1,202	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			16,003		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		16,003	6,416	19
20	30	Depreciation	Resident Days	440,525	23	24,996		16,003	908	20
21	32	Interest	Resident Days	440,525	23	933,842		16,003	33,924	21
22	33	Real Estate Taxes	Resident Days	440,525	23			16,003		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			16,003		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			16,003		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 62,097	25

Facility Name & ID Number

Countryview Care Center-Macomb

# 0047431

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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	Name of Lender	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	LaSalle Bank		X	Mortgage	Varies	1/19/2007	\$	425,000	421,016	12/31/2013	Varies	\$ 68,769	1					
2													2					
3								Home Office Allocation-PHC				2,763	3					
4								Home Office Allocation-PHO				33,924	4					
5													5					
<b>Working Capital</b>																		
6													6					
7													7					
8													8					
9	<b>TOTAL Facility Related</b>						\$	425,000	\$ 421,016			\$ 105,456	9					
<b>B. Non-Facility Related*</b>																		
10													10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$		\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$	425,000	\$ 421,016			\$ 105,456	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.)

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

	(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>Long-Term Care Facility</u>	\$ <u>38,645.00</u>	\$ <u>38,645.00</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>38,645.00</u>	\$ <u>38,645.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 Care Center-Macomb

# 0047431

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**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: \_\_\_\_\_ 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>103,237</u>	<u>2005</u>	<u>\$ 58,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>103,237</b>		<b>\$ 58,500</b>	<b>3</b>

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	\$ 105,700
5									
6									
7	Home Office Allocation			8,922			218	218	
8									
<b>Improvement Type**</b>									
9									
10	Land Improvement		2006	15,000		15	1,000	1,000	2,500
11	Windows		2007	524		15	17	17	17
12	Sprinkler System		2007	11,246		15	375	375	375
13									
14									
15									
16									
17									
18									
19	Building Booked				42,310			(42,310)	
20	Building Improvement Booked				1,447			(1,447)	
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			597			35	35	
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

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

\*\*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	\$ 207,218	\$ 30,622	\$ 29,731	\$ (891)	3-7	\$ 75,251	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,244	2,244			74
75	TOTALS	\$ 207,218	\$ 30,622	\$ 31,975	\$ 1,353		\$ 75,251	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	Facility	Ford E-150 2007	2007	\$ 27,198	\$ 1,813	\$ 2,720	\$ 907	5	\$ 2,720	76
77										77
78										78
79										79
80	TOTALS			\$ 27,198	\$ 1,813	\$ 2,720	\$ 907		\$ 2,720	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)	\$ 1,386,205	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,192	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 78,620	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,428	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 186,563	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: 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		<u>Home Office Allocation</u>			<u>32</u>			6
7	TOTAL				\$ <u>32</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 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: \$ 10,833 Description: See Schedule 14A

(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			<u>N/A</u>		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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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.

**Countryview Care Center-Macomb  
0047431**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 5,321
Dishwasher	610
Maintenance Equipment	193
Copier	4,287
Home Office Allocation	422
	<u>10,833</u>

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	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	10A(3)	hrs	\$	2,934	\$ 44,008	\$	2,934	\$ 44,008	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		57	1,245		57	1,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,929	43,940	139	2,929	44,079	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				15,778		15,778	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	<b>TOTAL</b>			\$	5,920	\$ 89,193	\$ 15,917	5,920	\$ 105,110	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.

Facility Name & ID Number Countryview Care Center-Macomb

# 0047431

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (1,216,986)	\$ (1,216,986)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	298,925	298,925	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,705	9,705	6
7	Other Prepaid Expenses	2,959	2,959	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (905,397)	\$ (905,397)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	73,500	58,500	13
14	Buildings, at Historical Cost	1,057,000	1,065,922	14
15	Leasehold Improvements, at Historical Cost	11,770	27,367	15
16	Equipment, at Historical Cost	234,416	234,416	16
17	Accumulated Depreciation (book methods)	(165,802)	(186,563)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,210,884	\$ 1,199,642	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 305,487	\$ 294,245	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 211,914	\$ 211,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,945	17,945	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,774	4,774	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	2,639	2,639	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	15,642	15,642	36
37	<u>Employee Advances</u>	200	200	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 293,114	\$ 293,114	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	421,016	421,016	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P-Prior Owner</u>	331	331	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 421,347	\$ 421,347	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 714,461	\$ 714,461	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (408,974)	\$ (420,216)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 305,487	\$ 294,245	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (180,500)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (180,500)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(228,474)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (228,474)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (408,974)	<b>24</b> *

\* This must agree with page 17, line 47.

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,414,578	1
2	Discounts and Allowances for all Levels	92,564	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,507,142	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	124,191	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 124,191	8
	<b>C. Other Operating Revenue</b>		
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	5,989	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,030	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,456	20
21	Other Medical Services	5,072	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 54,547	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	290	28
28a	Transportation Revenue	786	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,076	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,686,956	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	441,386	31
32	Health Care	737,181	32
33	General Administration	374,181	33
	<b>B. Capital Expense</b>		
34	Ownership	195,217	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	133,520	35
36	Provider Participation Fee	33,945	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,915,430	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(228,474)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (228,474)	43

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

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

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

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

Facility Name & ID Number Countryview Care Center-Macomb

# 0047431

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	2,080	2,080	\$ 45,640	\$ 21.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,940	3,971	82,591	20.80	3
4	Licensed Practical Nurses	7,154	7,243	116,025	16.02	4
5	CNAs & Orderlies	23,391	24,195	238,375	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	1,977	19,579	9.90	9
10	Activity Assistants	46	46	331	7.20	10
11	Social Service Workers	1,999	1,999	22,104	11.06	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,515	14.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,080	9,192	74,942	8.15	15
16	Dishwashers					16
17	Maintenance Workers	1,594	1,657	18,223	11.00	17
18	Housekeepers	8,077	8,422	67,276	7.99	18
19	Laundry	5,407	5,611	50,215	8.95	19
20	Administrator	2,080	2,080	58,534	28.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,049	2,177	32,235	14.81	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: Care Plan Coord.	2,080	2,080	34,181	16.43	32
33	Other(specify) <u>Marketing</u>	1,411	1,411	20,630	14.62	33
34	TOTAL (lines 1 - 33)	74,379	76,221	\$ 911,396 *	\$ 11.96	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	33	\$ 1,729	1(3)	35
36	Medical Director	Monthly	4,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	482	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					47
48					48
49	TOTAL (lines 35 - 48)	33	\$ 7,011		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				51
52	Certified Nurse Assistants/Aides	1,861	39,620	10(3)	52
53	TOTAL (lines 50 - 52)	1,861	\$ 39,620		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Tammy Bonney	Administrator	0	\$ 58,534	Workers' Compensation Insurance	\$ 11,498	IDPH License Fee	\$ 1,183		
				Unemployment Compensation Insurance	39,381	Advertising: Employee Recruitment	1,696		
				FICA Taxes	67,657	Health Care Worker Background Check			
				Employee Health Insurance	54,108	(Indicate # of checks performed )			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	164		
				Employee Relations	5,305	Home Office Allocation	636		
				Employee Retirement	742	Miscellaneous Licenses & Permits	606		
						IHCA Dues	2,043		
						LTC Solutions License	1,600		
						Less: Public Relations Expense	(420)		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,534	TOTAL (agree to Schedule V, line 22, col.8)		\$ 178,691	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,508
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 50,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 50,000				Seminar Expense	60	
							Home Office Allocation	415	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,313	TOTAL		\$	TOTAL	\$ 475	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Countryview Care Center-Macomb  
0047431**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
---------------------	-------------	---------------

Total (agree to Schedule V, line 19, column 3)		15,313
--	--	--------

**Home Office Allocation**

Pearl & Associates	Legal	18
Addy Bush & Assoc	Legal	9
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	39
Duane Morris	Legal	61
Ginoli & Co.	Accountants	1,993
RSM McGladrey	Accountants	107
McGladrey & Pullen	Accountants	163
Emdeon Business Services	Computer Services	42
Advanced Answers on Demand	Computer Services	1,148
Access 2 Go	Computer Services	87
Ivans	Computer Services	384
Kemper Technology	Computer Services	180
Adminastar Federal	Computer Services	22
LogmeIn	Computer Services	14
E-Health Data Solutions	Computer Services	112
Miscellaneous Vendors	Computer Services	15
Julie Breedlove	Computer Services	13
Amerisearch	Employment Fees	520

Total (agree to Schedule V, line 19, column 8)		<u>20,241</u>
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Facility Name &amp; ID Number Countryview Care Center-Macomb

# 0047431

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$2,043
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,457 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.
- (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? Yes Indicate the amount. \$ 5,989
- (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 & Company 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 still 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees