



Facility Name & ID Number Countryview Care Center-Macomb

# 0047431 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	5,856	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,692	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			944	944	8
9	SNF/PED					9
10	ICF	11,729	794		12,523	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,729	794	944	13,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.35%

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 944

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Countryview Care Center-Macomb # 0047431 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	121,866	11,106		132,972		132,972	2,394	135,366		1
2	Food Purchase		93,140		93,140		93,140	(7,494)	85,646		2
3	Housekeeping	82,876	10,141		93,017		93,017	18	93,035		3
4	Laundry	52,256	9,874		62,130		62,130	1	62,131		4
5	Heat and Other Utilities			54,423	54,423		54,423	248	54,671		5
6	Maintenance	23,197	9,055	22,132	54,384		54,384	2,198	56,582		6
7	Other (specify):* Home Off. Ben. All.							816	816		7
8	<b>TOTAL General Services</b>	280,195	133,316	76,555	490,066		490,066	(1,819)	488,247		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	507,687	51,648	99,611	658,946		658,946	4,154	663,100		10
10a	Therapy		96	98,900	98,996		98,996		98,996		10a
11	Activities	20,158	281	3,726	24,165		24,165		24,165		11
12	Social Services	25,429	23		25,452		25,452	6	25,458		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							725	725		15
16	<b>TOTAL Health Care and Programs</b>	553,274	52,048	207,037	812,359		812,359	4,885	817,244		16
	<b>C. General Administration</b>										
17	Administrative	41,933		82,000	123,933		123,933	(61,904)	62,029		17
18	Directors Fees										18
19	Professional Services			13,316	13,316		13,316	3,989	17,305		19
20	Dues, Fees, Subscriptions & Promotions			7,277	7,277		7,277	38	7,315		20
21	Clerical & General Office Expenses	30,952	5,900	13,464	50,316		50,316	26,929	77,245		21
22	Employee Benefits & Payroll Taxes			133,975	133,975		133,975		133,975		22
23	Inservice Training & Education			129	129		129	152	281		23
24	Travel and Seminar							152	152		24
25	Other Admin. Staff Transportation			3,948	3,948		3,948	5,243	9,191		25
26	Insurance-Prop.Liab.Malpractice			18,574	18,574		18,574	112	18,686		26
27	Other (specify):* Home Off. Ben. All.							7,690	7,690		27
28	<b>TOTAL General Administration</b>	72,885	5,900	272,683	351,468		351,468	(17,599)	333,869		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	906,354	191,264	556,275	1,653,893		1,653,893	(14,533)	1,639,360		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:

1/1/2008

Ending:

12/31/2008

## 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			80,096	80,096		80,096	3,562	83,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,580	27,580		27,580	8,585	36,165			32
33	Real Estate Taxes			42,053	42,053		42,053	342	42,395			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,659	10,659		10,659	291	10,950			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			160,388	160,388		160,388	12,780	173,168			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,043		27,043		27,043		27,043			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):* Non-allowable Cost	29,434	2,262	63,797	95,493		95,493	(95,493)				43
44	<b>TOTAL Special Cost Centers</b>	29,434	29,305	97,835	156,574		156,574	(95,493)	61,081			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	935,788	220,569	814,498	1,970,855		1,970,855	(97,246)	1,873,609			45

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

**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				4
5	Telephone, TV & Radio in Resident Rooms	(2,278)	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	178	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(495)	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	(2,560)	43		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	(41,177)	43		24
25	Fund Raising, Advertising and Promotional	(37,608)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(19,625)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (103,595)		\$	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
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	6,349	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 6,349		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (97,246)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Countryview Care Center-Macomb

ID# 0047431

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (10,799)	43	1
2	X-Rays-Part A	(541)	43	2
3	Resident Flowers	(46)	43	3
4	Offset Miscellaneous Food Revenue	(7,535)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(72)	21	5
6	Offset Chamber of Commerce Dues	(643)	20	6
7	Pet Expense	(8)	43	7
8	Disallowed Special Events	19	43	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
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31				31
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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>	(19,625)		49

**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%	\$ 2,394	\$ 2,394	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	39	39	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	248	248	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,463	1,463	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	589	589	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,154	4,154	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	725	725	10
11	V	17 Administrative	82,000	Petersen Health Care, Inc.	100.00%	18,634	(63,366)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,103	2,103	12
13	V							13
14	Total		\$ 82,000			\$ 30,368	\$ * (51,632)	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%	\$ 649	\$	649	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	23,384		23,384	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	142		142	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	142		142	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,841		1,841	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	112		112	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,657		6,657	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,548		2,548	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,792		1,792	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	342		342	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	291		291	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>		\$			\$ 37,900	\$ *	37,900	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%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	2	2	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	735	735	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	227	227	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	6	6	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,462	1,462	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,886	1,886	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	32	32	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	3,617	3,617	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	10	10	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	10	10	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	3,402	3,402	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,033	1,033	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	836	836	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	6,823	6,823	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 20,081	\$ *	20,081	39

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

Facility Name &amp; ID Number

Countryview Care Center-Macomb

# 0047431

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	1,810,040	0.56	0.93	Salary	18,634	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	\$ 18,634		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:

1/1/2008Ending: 2/31/2008

## 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 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	1,413,604	69	\$ 251,260	\$ 250,687	13,467	\$ 2,394	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	13,467	39	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	13,467	18	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	13,467	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	13,467	248	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	13,467	1,463	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	13,467	589	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	13,467	4,154	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	13,467	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	13,467	725	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	13,467	18,634	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	13,467	2,103	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	13,467	649	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	13,467	23,384	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	13,467	142	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	13,467	142	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	13,467	1,841	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	13,467	112	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	13,467	6,657	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	13,467	2,548	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	13,467	1,792	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	13,467	342	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	13,467	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	13,467	291	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 68,268	25

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

Report Period Beginning:

1/1/2008Ending: 2/31/2008

## 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 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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	419,957	23	\$	13,467	\$	1	
2	2	Food	Resident Days	419,957	23	68	13,467	2	2	
3	3	Housekeeping	Resident Days	419,957	23		13,467		3	
4	4	Laundry	Resident Days	419,957	23		13,467		4	
5	5	Utilities	Resident Days	419,957	23		13,467		5	
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	13,467	735	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067		13,467	227	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6		13,467		8
9	12	Social Services	Resident Days	419,957	23	187		13,467	6	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	13,467	1,462	10
11	19	Professional Services	Resident Days	419,957	23	58,812		13,467	1,886	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997		13,467	32	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798		13,467	3,617	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23			13,467		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299		13,467	10	15
16	24	Travel and Seminar	Resident Days	419,957	23	296		13,467	10	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105		13,467	3,402	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23			13,467		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211		13,467	1,033	19
20	30	Depreciation	Resident Days	419,957	23	26,070		13,467	836	20
21	32	Interest	Resident Days	419,957	23	212,765		13,467	6,823	21
22	33	Real Estate Taxes	Resident Days	419,957	23			13,467		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23			13,467		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23			13,467		24
25	TOTALS					\$ 626,192	\$ 55,582		\$ 20,081	25

Facility Name & ID Number

Countryview Care Center-Macomb

# 0047431

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		X	Mortgage	Varies	1/19/2007	\$	425,000	416,256	12/31/2013	Varies	\$	27,580	1						
2														2						
3								Interest Income Offset					(30)	3						
4								Home Office Allocation-PHC					1,792	4						
5								Home Office Allocation-PHO					6,823	5						
<b>Working Capital</b>																				
6														6						
7														7						
8														8						
9	<b>TOTAL Facility Related</b>						\$	425,000	\$	416,256		\$	36,165	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	\$	416,256		\$	36,165	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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<u>40,000</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<u>40,053</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>53</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>42,000</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<u>342</u>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>42,395</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	<u>38,714</u>	10
	2006	<u>38,645</u>	11
	2007	<u>40,053</u>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>40,053.24</u>	\$ <u>40,053.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,053.24</u>	\$ <u>40,053.24</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 12,290 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 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	\$ 147,980	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Land Improvement		2006	15,000		15	1,000	1,000	3,500	9
10	Windows		2007	524		15	35	35	52	10
11	Sprinkler System		2007	11,246		15	750	750	1,125	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	Building Booked				42,310			(42,310)		28
29	Building Improvement Booked				1,471			(1,471)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			468			30	30		32
33	2008-Home Office Allocation-Building Improvements			6,992			168	168		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

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)	\$ 1,091,230	\$ 43,781		\$ 44,263	\$ 482	\$ 152,657	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	\$ 30,232	\$ 29,731	\$ (501)	3-7 yrs.	\$ 104,982	71
72	Current Year Purchases	16,798	643	840	197	10 yrs.	840	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,384	3,384			74
75	TOTALS	\$ 224,016	\$ 30,875	\$ 33,955	\$ 3,080		\$ 105,822	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	\$ 5,440	\$ 5,440	\$	5	\$ 8,160	76
77										77
78										78
79										79
80	TOTALS			\$ 27,198	\$ 5,440	\$ 5,440	\$		\$ 8,160	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)	\$ 1,400,944	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,658	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 266,639	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					87
88	N/A				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?

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  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: \$ 10,950 Description: See Attached 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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 of 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	\$ 6,437
Dishwasher	769
Maintenance Equipment	230
Copier	3,134
Laundry	89
Home Office Allocation	291
	<u>10,950</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>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	<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	\$	2,800	\$ 42,000	\$	2,800	\$ 42,000	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		91	1,364		91	1,364	2
3	Licensed Recreational Therapist		hrs		8	123		8	123	3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		3,694	55,413	96	3,694	55,509	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				27,043		27,043	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	6,593	\$ 98,900	\$ 27,139	6,593	\$ 126,039	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (1,279,939)	\$ (1,279,939)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A )	328,537	328,537	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,508	15,508	6
7	Other Prepaid Expenses	7,610	7,610	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>	\$ (928,284)	\$ (928,284)	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	1,063,992	14
15	Leasehold Improvements, at Historical Cost	11,770	27,238	15
16	Equipment, at Historical Cost	251,214	251,214	16
17	Accumulated Depreciation (book methods)	(245,897)	(236,908)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,147,587	\$ 1,164,036	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 219,303	\$ 235,752	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 326,106	\$ 326,106	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,132	18,132	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,798	4,798	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000	42,000	32
33	Accrued Interest Payable	2,083	2,083	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	15,455	15,455	36
37	<u>Due To Related Parties</u>	103,573	103,573	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 512,147	\$ 512,147	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	416,256	416,256	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 416,256	\$ 416,256	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 928,403	\$ 928,403	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (709,100)	\$ (692,651)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 219,303	\$ 235,752	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (408,974)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (408,976)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(300,124)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (300,124)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (709,100)	24 *

\* 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	\$ 1,404,549	1
2	Discounts and Allowances for all Levels	60,615	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,465,164	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	136,347	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 136,347	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	7,535	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,969	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,180	20
21	Other Medical Services	1,434	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 69,118	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	72	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 72	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,670,731	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	490,066	31
32	Health Care	812,359	32
33	General Administration	351,468	33
	<b>B. Capital Expense</b>		
34	Ownership	160,388	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	122,536	35
36	Provider Participation Fee	34,038	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,970,855	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(300,124)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (300,124)	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 part of 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: 1/1/2008

Ending: 12/31/2008

**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	1,864	1,864	\$ 45,294	\$ 24.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,199	2,263	51,641	22.82	3
4	Licensed Practical Nurses	6,354	6,547	114,303	17.46	4
5	CNAs & Orderlies	24,224	24,986	261,253	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,860	2,038	20,144	9.88	9
10	Activity Assistants	2	2	14	7.00	10
11	Social Service Workers	2,053	2,146	25,429	11.85	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,356	15.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,553	9,931	89,510	9.01	15
16	Dishwashers					16
17	Maintenance Workers	1,991	2,008	23,197	11.55	17
18	Housekeepers	9,445	9,730	82,876	8.52	18
19	Laundry	5,232	5,438	52,256	9.61	19
20	Administrator	1,757	1,757	41,933	23.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,898	2,090	30,952	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	35,196	16.92	32
33	Other(specify) <u>Marketing</u>	2,080	2,080	29,434	14.15	33
34	TOTAL (lines 1 - 33)	74,672	77,040	\$ 935,788 *	\$ 12.15	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			35
36	Medical Director	Monthly 4,800	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	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)	\$ 5,400		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	164 \$ 8,502	10(3)	50
51	Licensed Practical Nurses	1,076 46,516	10(3)	51
52	Certified Nurse Assistants/Aides	1,965 41,245	10(3)	52
53	TOTAL (lines 50 - 52)	3,205 \$ 96,263		53

Countryview Care Center-Macomb  
0047431  
Period Beginning 1/1/2008  
Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing	1,864	1,864	45,294	24.30
Assistant Director of Nsg.				
Registered Nurses	2,199	2,263	51,641	22.82
Licensed Practical Nurses	6,354	6,547	114,303	17.46
Nurse Aides & Orderlies	24,207	24,969	261,125	10.46
Daily Living Aides	17	17	128	7.53
Licensed Therapist				
Activity Director	1,860	2,038	20,144	9.88
Activity Assistants	2	2	14	7.00
Social Service Workers	2,053	2,146	25,429	11.85
Dietician				
Food Service Supervisor	2,080	2,080	32,356	15.56
Head Cook				
Cook Helpers/Assistants	9,553	9,931	89,510	9.01
Dishwashers				
Maintenance Workers	1,991	2,008	23,197	11.55
Housekeepers	9,445	9,730	82,876	8.52
Laundry	5,232	5,438	52,256	9.61
Administrator	1,757	1,757	41,933	23.87
Assistant Administrator				
Other Administrative				
Office Manager	1,898	2,090	30,952	14.81
Clerical				
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records				
Care Plan Coordinator	2,080	2,080	35,196	16.92
Physical Therapy Aide				
COTA				
Social Service Asst				
Marketing	2,080	2,080	29,434	
<b>TOTAL (lines 1 - 35)</b>	<b>74,672</b>	<b>77,040</b>	<b>935,788</b>	

**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	
<u>Tammy Bonney</u>	<u>Administrator</u>	<u>0</u>	\$ <u>9,167</u>	<u>Workers' Compensation Insurance</u>	\$ <u>21,606</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Joy Carlson</u>	<u>Administrator</u>	<u>0</u>	<u>32,766</u>	<u>Unemployment Compensation Insurance</u>	<u>30,163</u>	<u>Advertising: Employee Recruitment</u>	<u>1,723</u>	
				<u>FICA Taxes</u>	<u>68,519</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>13,041</u>	(Indicate # of checks performed )		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>67</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Permits</u>	<u>756</u>	
				<u>Smoking Cessation Reimbursement</u>	<u>69</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>678</u>	
				<u>Employee Retirement</u>	<u>577</u>	<u>IHCA Dues</u>	<u>1,460</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>41,933</u></b>			<u>Home Office Allocation</u>	<u>681</u>	
<b>(List each licensed administrator separately.)</b>						<b>Less: Public Relations Expense</b>	<b>(643)</b>	
<b>B. Administrative - Other</b>						<u>Non-allowable advertising</u>	( )	
Description			Amount			<u>Yellow page advertising</u>	( )	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>82,000</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>82,000</u></b>	<b>TOTAL (agree to Schedule V,</b>	<b>\$ <u>133,975</u></b>	<b>TOTAL (agree to Sch. V,</b>	<b>\$ <u>7,315</u></b>	
<b>(Attach a copy of any management service agreement)</b>				<b>line 22, col.8)</b>		<b>line 20, col. 8)</b>		
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Heyl, Royster, Voelker, Allen</u>	<u>Legal Services</u>		\$ <u>4,899</u>				<u>Out-of-State Travel</u>	\$
<u>Linden Engineering</u>	<u>Accounting Services</u>		<u>3,393</u>					
<u>Logonix Corporation</u>	<u>Computer Services</u>		<u>657</u>					
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>2,700</u>				<u>In-State Travel</u>	
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,600</u>	<u>N/A</u>				
<u>Insight Communications</u>	<u>Computer Services</u>		<u>50</u>					
<u>Misc. Vendors</u>	<u>Computer Services</u>		<u>17</u>				<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>152</u>
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>13,316</u></b>	<b>TOTAL</b>		<b>\$</b>	<b>(agree to Sch. V,</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>line 24, col. 8)</b>	<b>\$ <u>152</u></b>

\* Attach copy of IMRF notifications

\*\*See instructions.

**Countryview Care Center-Macomb**

**0047431**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**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)		13,316

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	153
GoffWilson, P.A.	Legal	255
Ginoli & Company	Accountants	2,136
RSM McGladrey	Accountants	6
Miscellaneous Vendors	Computer Services	30
Emdeon Business Services	Computer Services	41
Advanced Answers on Demand	Computer Services	483
Access 2 Go	Computer Services	143
Ivans	Computer Services	330
Kemper Technology	Computer Services	262
VisionShare	Computer Services	28
Logmein	Computer Services	20
Comm Net Communiations	Computer Services	7
Charter Communications	Computer Services	6
Advanced System Designs	Computer Services	9
Consolidated Communications	Computer Services	6
Miscellaneous Vendors	Miscellaneous	74

Total (agree to Schedule V, line 19, column 8)		<u>17,305</u>
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**Countryview Care Center-Macomb**

**0047431**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>
Tammy Bonney	Administrator	0	9,167
Joy Carlson	Administrator	0	32,766
	<b>Total</b>		<b>41,933</b>

Countryview Care Center-Macomb  
 0047431  
 Period Beginning  
 Period End

Schedule 21A

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker & Allen	279.50	100%	280
Heyl, Royster, Voelker & Allen	2,774.52	100%	2,775
Heyl, Royster, Voelker & Allen	274.91	100%	275
Heyl, Royster, Voelker & Allen	430.40	100%	430
Heyl, Royster, Voelker & Allen	966.00	100%	966
Heyl, Royster, Voelker & Allen	173.29	100%	173
<b>Home Office Allocation</b>			
Heyl, Royster, Voelker & Allen	8,021.00	0.95%	76
GoffWilson, P.A.	26,797.00	0.95%	255
<b>Management Company Allocation</b>			
Heyl, Royster, Voelker & Allen	2,406.00	3.20%	77
<b>Total Legal Fees</b>			5,306



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

# 0047431

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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. 1,460 -IHCA
- (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? No
- (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. \$ 14,765 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? N/A  
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. \$ 34,038  
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. \$ 7,535
- (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. \$ No
- 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (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 currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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