

Facility Name & ID Number Countryview Terrace

0046078 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,453</u>			<u>5,453</u>	13
14	TOTALS	<u>5,453</u>			<u>5,453</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.12%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 2/10/96

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/10/96 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL 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 Terrace # 0046078 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
	A. General Services										
1	Dietary	25,625	2,444		28,069		28,069	969	29,038		1
2	Food Purchase		18,941		18,941		18,941	16	18,957		2
3	Housekeeping	2,347	2,283		4,630		4,630	7	4,637		3
4	Laundry		1,337		1,337		1,337		1,337		4
5	Heat and Other Utilities			14,534	14,534		14,534	100	14,634		5
6	Maintenance	1,994	2,116	13,606	17,716		17,716	592	18,308		6
7	Other (specify):* Home Off. Ben. All.							238	238		7
8	TOTAL General Services	29,966	27,121	28,140	85,227		85,227	1,922	87,149		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	132,539	6,006	2,798	141,343		141,343	1,682	143,025		10
10a	Therapy										10a
11	Activities	3,513	520	606	4,639		4,639	(1,300)	3,339		11
12	Social Services	21,775			21,775		21,775		21,775		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							294	294		15
16	TOTAL Health Care and Programs	157,827	6,526	5,804	170,157		170,157	676	170,833		16
	C. General Administration										
17	Administrative	24,841			24,841		24,841	7,545	32,386		17
18	Directors Fees										18
19	Professional Services							852	852		19
20	Dues, Fees, Subscriptions & Promotions			976	976		976	263	1,239		20
21	Clerical & General Office Expenses		3,325	5,389	8,714		8,714	9,464	18,178		21
22	Employee Benefits & Payroll Taxes			22,308	22,308		22,308		22,308		22
23	Inservice Training & Education			345	345		345	58	403		23
24	Travel and Seminar							58	58		24
25	Other Admin. Staff Transportation			6,817	6,817		6,817	746	7,563		25
26	Insurance-Prop.Liab.Malpractice			3,602	3,602		3,602	45	3,647		26
27	Other (specify):* Home Off. Ben. All.							2,696	2,696		27
28	TOTAL General Administration	24,841	3,325	39,437	67,603		67,603	21,727	89,330		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	212,634	36,972	73,381	322,987		322,987	24,325	347,312		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 & ID Number

Countryview Terrace

#0046078

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	
	D. Ownership											
30	Depreciation			18,314	18,314		18,314	2,818	21,132			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,136	55,136		55,136	726	55,862			32
33	Real Estate Taxes			5,920	5,920		5,920	138	6,058			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							118	118			35
36	Other (specify):*											36
37	TOTAL Ownership			79,370	79,370		79,370	3,800	83,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,978	28,978		28,978		28,978			42
43	Other (specify):* Non-allowable Cost			2,786	2,786		2,786	(2,786)				43
44	TOTAL Special Cost Centers			31,764	31,764		31,764	(2,786)	28,978			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	212,634	36,972	184,515	434,121		434,121	25,339	459,460			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	(1,805)	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	1,786	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				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	(375)	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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(1,911)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,305)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	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)	27,644	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,644		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 25,339		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	TOTAL (C): (sum of lines 38-46)			\$		47

Countryview Terrace

ID# 0046078

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Travel Revenue	(1,300)	25	1
2	Offset Miscellaneous Office Supplies Revenue	(5)	21	2
3	Resident Flowers	(27)	43	3
4	Disallowed Special Events	(579)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,911)		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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 969	\$	969	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	16		16	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	7		7	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0			4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	100		100	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	592		592	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	238		238	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,682		1,682	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%	294		294	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	7,545		7,545	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	852		852	12
13	V								13
14	Total		\$			\$ 12,295	\$ *	12,295	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 Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 263	\$	263	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	9,469		9,469	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	58		58	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	58		58	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	746		746	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	45		45	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,696		2,696	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,032		1,032	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	726		726	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	138		138	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%	118		118	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 15,349	\$ *	15,349	39

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

Facility Name & ID Number

Countryview Terrace

0046078

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	1,821,129	0.23	0.38	Salary	7,545	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,545		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 Terrace

0046078

Report Period Beginning:

1/1/2008

Ending: 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	5,453	\$ 969	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	5,453	16	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	5,453	7	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	5,453	0	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	5,453	100	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	5,453	592	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	5,453	238	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	5,453	1,682	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	5,453	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	5,453	294	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	5,453	7,545	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	5,453	852	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	5,453	263	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	5,453	9,469	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	5,453	58	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	5,453	58	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	5,453	746	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	5,453	45	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	5,453	2,696	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	5,453	1,032	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	5,453	726	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	5,453	138	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	5,453	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	5,453	118	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 27,644	25

Facility Name & ID Number

Countryview Terrace

0046078

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank of America		X	Mortgage	varies	08/31/02	\$ 877,500	\$ 855,744	12/31/13	varies	\$ 55,136	1				
2												2				
3												3				
4							Home Office Allocation-PHC				726	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 877,500	\$ 855,744			\$ 55,862	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 877,500	\$ 855,744			\$ 55,862	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.		\$	5,600	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	\$	5,520	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(80)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,000	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		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. Home Office Allocation			138	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	6,058	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	4,596	8
	2004	4,932	9
	2005	4,965	10
	2006	5,429	11
	2007	5,520	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
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 Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046078

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. 02-15-100-030	Long-Term Care Facility	\$ 5,519.80	\$ 5,519.80
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>5,519.80</u>	\$ <u>5,519.80</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 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.

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel Number of Stories _____

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>402,390</u>	<u>1996</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	402,390		\$ 10,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1996	1976	\$ 579,889	\$	35	\$ 16,568	\$ 16,568	\$ 215,258	4
5										5
6										6
7	Home Office Allocation									7
8										8
	Improvement Type**									
9	Land Survey		1996	1,700		20	85	85	1,077	9
10	Curtains		1996	307		20	15	15	188	10
11	Pump Repairs		1996	1,163		20	58	58	740	11
12	Repiping Water Heater		1996	1,681		20	84	84	1,057	12
13	Fence		1997	2,469		20	123	123	1,384	13
14	Plumbing		1997	1,234		20	62	62	723	14
15	Handicapped Showers & Ramp		1998	1,962		20	98	98	1,029	15
16	Landscaping		2000	4,289		20	214	214	1,819	16
17	Drainage and Sidewalk		2001	2,557		20	128	128	961	17
18	Roof		2001	8,701		20	435	435	3,263	18
19	Water Supply		2002	2,413		20	121	121	786	19
20	Roof		2004	900		20	45	45	203	20
21	Bathroom Sinks and Showers		2004	12,800		20	640	640	2,880	21
22	Furnace		2007	5,428		20	271	271	407	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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			149			(149)		45
46			14,869			(14,869)		46
47			2,091			(2,091)		47
48								48
49								49
50		189			12	12		50
51		2,831			68	68		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		\$ 630,513	\$ 17,109		\$ 19,027	\$ 1,918	\$ 231,775	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	\$ 47,382	\$ 1,023	\$ 1,003	\$ (20)	10	\$ 44,101	71
72	Current Year Purchases	1,397	183	70	(113)	10	70	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,032	1,032			74
75	TOTALS	\$ 48,779	\$ 1,206	\$ 2,105	\$ 899		\$ 44,171	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Use	1995 Dodge Maxivan	1999	\$ 9,986	\$	\$	\$	5	\$ 9,986	76
77										77
78										78
79										79
80	TOTALS			\$ 9,986	\$	\$	\$		\$ 9,986	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 699,278	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,315	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,132	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,817	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 285,932	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: \$ 118 Description: Home Office Allocation

(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. _____ /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.

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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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	TOTAL			\$		\$	\$		\$	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 Terrace

0046078

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,019,050	\$ 1,019,050	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	59,804	59,804	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,966	3,966	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,121	116,121	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,198,941	\$ 1,198,941	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost	579,889	582,720	14
15	Leasehold Improvements, at Historical Cost	53,526	47,793	15
16	Equipment, at Historical Cost	58,765	58,765	16
17	Accumulated Depreciation (book methods)	(256,747)	(285,932)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 435,433	\$ 413,346	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,634,374	\$ 1,612,287	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 111,187	\$ 111,187	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,647	12,647	30
31	Accrued Taxes Payable (excluding real estate taxes)	879	879	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,000	6,000	32
33	Accrued Interest Payable	5,041	5,041	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	3,371	3,371	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 139,125	\$ 139,125	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	855,744	855,744	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 855,744	\$ 855,744	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 994,869	\$ 994,869	46
47	TOTAL EQUITY(page 18, line 24)	\$ 639,505	\$ 617,418	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,634,374	\$ 1,612,287	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 553,700	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 553,703	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,802	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)	\$ 85,802	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 639,505	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 518,618	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 518,618	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	1,300	28
28a	Miscellaneous Revenue	5	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,305	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 519,923	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	85,227	31
32	Health Care	170,157	32
33	General Administration	67,603	33
	B. Capital Expense		
34	Ownership	79,370	34
	C. Ancillary Expense		
35	Special Cost Centers	2,786	35
36	Provider Participation Fee	28,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 434,121	40
41	Income before Income Taxes (line 30 minus line 40)**	85,802	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 85,802	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 Terrace

0046078

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
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	2,647	19,964	7.20	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	625	3,513	5.49	9
10	Activity Assistants				10
11	Social Service Workers	1,951	21,775	10.47	11
12	Dietician				12
13	Food Service Supervisor	2,025	25,625	12.13	13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	191	1,994	10.44	17
18	Housekeepers	289	2,347	8.12	18
19	Laundry				19
20	Administrator	1,647	24,841	14.66	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	13,245	107,793	7.96	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>QA Nurse</u>	194	4,782	24.65	33
34	TOTAL (lines 1 - 33)	22,814	212,634 *	9.04	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 2,400	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 400	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) <u>Psychologist</u>	18 visits 1,659	10(3)	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 4,459		49

C. CONTRACT NURSES

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

Facility Name & ID Number Countryview Terrace

0046078

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. 620 -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. \$ 876 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. \$ 28,978
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? No Indicate the amount. \$ 0
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees