

Facility Name & ID Number Countryview Terrace

0046078 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,206		134	5,340	13
14	TOTALS	5,206		134	5,340	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

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 2/10/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	26,808	2,409		29,217		29,217	934	30,151		1
2	Food Purchase		21,405		21,405		21,405	21	21,426		2
3	Housekeeping	14,394	2,714		17,108		17,108	9	17,117		3
4	Laundry		3,079		3,079		3,079		3,079		4
5	Heat and Other Utilities			15,242	15,242		15,242	92	15,334		5
6	Maintenance	186	2,330	9,922	12,438		12,438	452	12,890		6
7	Other (specify):* Home Off. Ben. All.							169	169		7
8	TOTAL General Services	41,388	31,937	25,164	98,489		98,489	1,677	100,166		8
	B. Health Care and Programs										
9	Medical Director			3,129	3,129		3,129		3,129		9
10	Nursing and Medical Records	139,879	6,153	2,975	149,007		149,007	565	149,572		10
10a	Therapy										10a
11	Activities	19,902	792	331	21,025		21,025	(68)	20,957		11
12	Social Services	26,228			26,228		26,228		26,228		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							70	70		15
16	TOTAL Health Care and Programs	186,009	6,945	6,435	199,389		199,389	567	199,956		16
	C. General Administration										
17	Administrative	7,500			7,500		7,500	25,711	33,211		17
18	Directors Fees										18
19	Professional Services			105	105		105	1,309	1,414		19
20	Dues, Fees, Subscriptions & Promotions			3,438	3,438		3,438	365	3,803		20
21	Clerical & General Office Expenses		5,236	6,536	11,772		11,772	8,866	20,638		21
22	Employee Benefits & Payroll Taxes			31,180	31,180		31,180		31,180		22
23	Inservice Training & Education							97	97		23
24	Travel and Seminar							30	30		24
25	Other Admin. Staff Transportation			5,540	5,540		5,540	469	6,009		25
26	Insurance-Prop.Liab.Malpractice			5,341	5,341		5,341	195	5,536		26
27	Other (specify):* Home Off. Ben. All.							2,556	2,556		27
28	TOTAL General Administration	7,500	5,236	52,140	64,876		64,876	39,598	104,474		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	234,897	44,118	83,739	362,754		362,754	41,842	404,596		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:

1/1/2009

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			18,314	18,314		18,314	2,006	20,320			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,448	47,448		47,448	1,184	48,632			32
33	Real Estate Taxes			6,061	6,061		6,061	118	6,179			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			952	952		952	113	1,065			35
36	Other (specify):*											36
37	TOTAL Ownership			72,775	72,775		72,775	3,421	76,196			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			29,028	29,028		29,028		29,028			42
43	Other (specify):* Non-allowable Cost			2,393	2,393		2,393	(2,393)				43
44	TOTAL Special Cost Centers			31,421	31,421		31,421	(2,393)	29,028			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	234,897	44,118	187,935	466,950		466,950	42,870	509,820			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	(1,874)	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	1,236	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	(144)	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	(1,099)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,881)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	44,751	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 44,751		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 42,870		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	(68)	11	1
2	Offset Miscellaneous Office Supplies Revenue	(8)	21	2
3	Disallowed Special Events	(375)	43	3
4	Credit Received from Telephone Company	(648)	21	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	(1,099)		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%	\$ 934	\$ 934	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	21	21	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	9	9	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	92	92	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	452	452	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	169	169	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	565	565	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%	70	70	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	25,711	25,711	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,309	1,309	12	
13	V							13	
14	Total		\$			\$ 29,332	\$ *	29,332	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%	\$ 365	\$	365	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	9,522		9,522	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	97		97	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	30		30	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	469		469	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	195		195	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,556		2,556	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	770		770	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,184		1,184	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	118		118	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%	113		113	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		\$			\$ 15,419	\$ *	15,419	39

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

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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	158,506	0.21	0.35	Salary	\$ 607	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	\$ 607		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

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1/1/2009

Ending: 2/31/2009

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	1,493,044	75	\$ 261,102	\$ 259,584	5,340	\$ 934	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	5,340	21	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	5,340	9	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	5,340	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	5,340	92	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	5,340	452	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	5,340	169	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	5,340	565	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	5,340	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	5,340	70	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	5,340	25,711	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	5,340	1,309	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	5,340	365	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	5,340	9,522	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	5,340	97	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	5,340	30	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	5,340	469	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	5,340	195	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	5,340	2,556	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	5,340	770	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	5,340	1,184	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	5,340	118	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	5,340	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	5,340	113	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 44,751	25

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	varies	08/31/02	\$ 877,500	\$ 842,945	12/31/13	Varies	\$ 47,448	1							
2												2							
3												3							
4							Home Office Allocation-PHC				1,184	4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 877,500	\$ 842,945			\$ 48,632	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	\$ 842,945			\$ 48,632	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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel 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>402,390</u>	<u>1996</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	402,390		\$ 10,000	3

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12/31/2009

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	\$ 231,826
5										
6										
7										
8										
	Improvement Type**									
9	Land Survey		1996		1,700		20	85	85	1,162
10	Curtains		1996		307		20	15	15	203
11	Pump Repairs		1996		1,163		20	58	58	798
12	Repiping Water Heater		1996		1,681		20	84	84	1,141
13	Fence		1997		2,469		20	123	123	1,507
14	Plumbing		1997		1,234		20	62	62	785
15	Handicapped Showers & Ramp		1998		1,962		20	98	98	1,127
16	Landscaping		2000		4,289		20	214	214	2,033
17	Drainage and Sidewalk		2001		2,557		20	128	128	1,089
18	Roof		2001		8,701		20	435	435	3,698
19	Water Supply		2002		2,413		20	121	121	907
20	Roof		2004		900		20	45	45	248
21	Bathroom Sinks and Showers		2004		12,800		20	640	640	3,520
22	Furnace		2007		5,428		20	271	271	678
23										
24										
25										
26										
27	Land Improvements Booked					149			(149)	
28	Building Booked					14,869			(14,869)	
29	Building Improvement Booked					2,091			(2,091)	
30										
31										
32	2009-Home Office Allocation-Land Improvements				176			11	11	
33	2009-Home Office Allocation-Building Improvements				2,625			63	63	
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 630,294	\$ 17,109		\$ 19,021	\$ 1,912	\$ 250,722	70

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

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 5,288	\$ 1,205	\$ 529	\$ (676)	10 yrs.	\$ 1,238	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	43,492					43,492	73
74	Home Office Allocation			770	770			74
75	TOTALS	\$ 48,780	\$ 1,205	\$ 1,299	\$ 94		\$ 44,730	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	\$	\$	\$		\$ 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)	\$ 699,060	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,314	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,320	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,006	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 305,438	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: \$ 1,065 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			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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 Terrace
0046078**

Period Beginning

1/1/2009

Period End

12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	952
Home Office Allocation		113
		<u>1,065</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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	4					
					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# 0046078Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 902,409	\$ 902,409	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	176,830	176,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,976	7,976	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)	\$ 1,203,336	\$ 1,203,336	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	582,514	14
15	Leasehold Improvements, at Historical Cost	53,526	47,780	15
16	Equipment, at Historical Cost	58,765	58,766	16
17	Accumulated Depreciation (book methods)	(275,061)	(305,438)	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)	\$ 417,119	\$ 393,622	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,620,455	\$ 1,596,958	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,609	\$ 29,609	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,380	12,380	30
31	Accrued Taxes Payable (excluding real estate taxes)	979	979	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,100	6,100	32
33	Accrued Interest Payable	4,309	4,309	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	13,595	13,595	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 66,972	\$ 66,972	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	842,945	842,945	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)	\$ 842,945	\$ 842,945	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 909,917	\$ 909,917	46
47	TOTAL EQUITY(page 18, line 24)	\$ 710,538	\$ 687,041	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,620,455	\$ 1,596,958	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 639,505	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 639,505	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,033	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)	\$ 71,033	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)	\$ 710,538	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Countryview Terrace# 0046078Report Period Beginning: 1/1/2009Ending: 12/31/2009

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	\$ 537,259	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 537,259	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	Miscellaneous Revenue	656	28
28a	Transportation	68	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 724	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 537,983	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	98,489	31
32	Health Care	199,389	32
33	General Administration	64,876	33
B. Capital Expense			
34	Ownership	72,775	34
C. Ancillary Expense			
35	Special Cost Centers	2,393	35
36	Provider Participation Fee	29,028	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 466,950	40
41	Income before Income Taxes (line 30 minus line 40)**	71,033	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,033	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:

1/1/2009

Ending:

12/31/2009

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	225	4,400	19.56	3
4	Licensed Practical Nurses	111	2,214	19.95	4
5	CNAs & Orderlies	1,655	13,027	7.87	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,248	19,902	8.61	9
10	Activity Assistants				10
11	Social Service Workers	2323	26,228	10.59	11
12	Dietician				12
13	Food Service Supervisor	1,906	26,193	11.98	13
14	Head Cook				14
15	Cook Helpers/Assistants	79	615	7.78	15
16	Dishwashers				16
17	Maintenance Workers	16	186	11.63	17
18	Housekeepers	1,785	14,394	8.06	18
19	Laundry				19
20	Administrator	2,160	32,604	15.09	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)	14,528	14,891	8.07	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	27,036	27,898	\$ 260,001 *	\$ 9.32 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 3,129	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 550	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>	25 visits 2,375	10(3)	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 6,054		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

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	
Amber Schumacher	Administrator	0	\$ 27,404	Workers' Compensation Insurance	\$ 9,220	IDPH License Fee	\$	
Terri Mulvaney	Administrator	0	5,200	Unemployment Compensation Insurance	4,712	Advertising: Employee Recruitment	1,782	
				FICA Taxes	17,728	Health Care Worker Background Check		
				Employee Health Insurance	(632)	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	150	
				Employee Relations	111	Miscellaneous Dues & Subscriptions	6	
				Employee Retirement	41	IHCA Dues	1,500	
						Home Office Allocation	365	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 32,604			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 31,180	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,803	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Wabash Telephone Cooperative	Computer Services		\$ 105				Out-of-State Travel	\$
				N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	30
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 105	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 30

* Attach copy of IMRF notifications

**See instructions.

Countryview Terrace

0046078

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		105

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	8
GoffWilson, P.A.	Legal	12
Jackson Lewis	Legal	94
Peter Gartelos	Legal	9
Misc.	Legal	8
Ginoli & Company	Accountants	208
Miscellaneous Vendors	Computer Services	9
Emdeon Business Services	Computer Services	4
Advanced Answers on Demand	Computer Services	503
Access 2 Go	Computer Services	48
Ivans	Computer Services	6
Kemper Technology	Computer Services	137
VisionShare	Computer Services	43
MediFax	Computer Services	17
LogmeIn	Computer Services	8
Charter Communications	Computer Services	-
Simple LTC	Computer Services	116
Miscellaneous Vendors	Miscellaneous	80

Total (agree to Schedule V, line 19, column 8)	<u>1,415</u>
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Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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. 1,500 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. \$ 550 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. \$ 29,028
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. \$ N/A
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.