

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046078</u></p> <p>Facility Name: <u>Countryview Terrace</u></p> <p>Address: <u>52 Old Route 45, P.O. Box 116</u> <u>Louisville</u> <u>62858</u> Number City Zip Code</p> <p>County: <u>Clay</u></p> <p>Telephone Number: <u>(618) 686-4542</u> Fax # <u>(618) 686-2179</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>02/01/96</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 689-5869</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2010</u> to <u>12/31/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Print Name and Title) _____																																				
	(Firm Name & Address) _____																																				
	(Telephone) <u>()</u> Fax # <u>()</u>																																				

Facility Name & ID Number Countryview Terrace

0046078 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	4,609			4,609	13
14	TOTALS	4,609			4,609	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.92%

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 2/10/1996 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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	27,375	1,985		29,360		29,360	858	30,218		1
2	Food Purchase		20,376		20,376		20,376		20,376		2
3	Housekeeping		3,526		3,526		3,526	10	3,536		3
4	Laundry		1,088		1,088		1,088		1,088		4
5	Heat and Other Utilities			15,761	15,761		15,761	85	15,846		5
6	Maintenance	1,758	2,335	13,118	17,211		17,211	500	17,711		6
7	Other (specify):* Home Off. Ben. All.							201	201		7
8	TOTAL General Services	29,133	29,310	28,879	87,322		87,322	1,654	88,976		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	131,474	5,210	2,634	139,318		139,318	13	139,331		10
10a	Therapy										10a
11	Activities	24,196	369	479	25,044		25,044		25,044		11
12	Social Services	23,196	116		23,312		23,312		23,312		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	178,866	5,695	6,713	191,274		191,274	13	191,287		16
	C. General Administration										
17	Administrative			50,000	50,000		50,000	(7,812)	42,188		17
18	Directors Fees										18
19	Professional Services			3,420	3,420		3,420	951	4,371		19
20	Dues, Fees, Subscriptions & Promotions			592	592		592	236	828		20
21	Clerical & General Office Expenses		3,074	1,841	4,915		4,915	8,520	13,435		21
22	Employee Benefits & Payroll Taxes			26,043	26,043		26,043		26,043		22
23	Inservice Training & Education							61	61		23
24	Travel and Seminar							7	7		24
25	Other Admin. Staff Transportation			3,087	3,087		3,087	769	3,856		25
26	Insurance-Prop.Liab.Malpractice			6,244	6,244		6,244	127	6,371		26
27	Other (specify):* Home Off. Ben. All.							3,487	3,487		27
28	TOTAL General Administration		3,074	91,227	94,301		94,301	6,346	100,647		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	207,999	38,079	126,819	372,897		372,897	8,013	380,910		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:

1/1/2010

Ending:

12/31/2010

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			18,280	18,280		18,280	2,249	20,529			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,925	45,925		45,925	1,140	47,065			32
33	Real Estate Taxes			5,954	5,954		5,954	(20)	5,934			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,128	2,128		2,128	118	2,246			35
36	Other (specify):*											36
37	TOTAL Ownership			72,287	72,287		72,287	3,487	75,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89		89		89		89			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,288	28,288		28,288		28,288			42
43	Other (specify):* Non-allowable Cost		40	25,121	25,161		25,161	(25,161)				43
44	TOTAL Special Cost Centers		129	53,409	53,538		53,538	(25,161)	28,377			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	207,999	38,208	252,515	498,722		498,722	(13,661)	485,061			45

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

Countryview Terrace

ID# 0046078

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Real Estate Tax Late Fee	(142)	33	1
2	Offset Miscellaneous Office Supplies Revenue	(25)	21	2
3	Disallowed Special Events	(117)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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	(284)		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 B. 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%	\$ 858	\$ 858	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	10	10	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	85	85	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	500	500	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	201	201	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13	13	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%	0		10
11	V	17 Administrative	50,000	Petersen Health Care, Inc.	100.00%	42,188	(7,812)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	951	951	12
13	V							13
14	Total		\$ 50,000			\$ 44,806	\$ * (5,194)	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%	\$ 236	\$	236	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	8,545		8,545	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	61		61	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7		7	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	769		769	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	127		127	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,487		3,487	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	989		989	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,140		1,140	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	122		122	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		\$			\$ 15,601	\$ *	15,601	39

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

Facility Name & ID Number

Countryview Terrace

0046078

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	181,664	0.17	0.29	Salary	\$ 586	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	\$ 586		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:

1/1/2010Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	4,609	\$ 858	1
2	2	Food	Resident Days	1,527,029	77	0	0	4,609	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	4,609	10	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	4,609	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	4,609	85	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	4,609	500	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	4,609	201	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	4,609	13	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	4,609	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	4,609	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	4,609	42,188	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	4,609	951	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	4,609	236	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	4,609	8,545	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	4,609	61	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	4,609	7	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	4,609	769	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	4,609	127	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	4,609	3,487	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	4,609	989	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	4,609	1,140	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	4,609	122	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	4,609	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	4,609	118	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 60,407	25

Facility Name & ID Number

Countryview Terrace

0046078

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$ 829,038	12/31/13	Varies	\$ 45,925	1							
2												2							
3												3							
4							Home Office Allocation-PHC				1,140	4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 877,500	\$ 829,038			\$ 47,065	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	\$ 829,038			\$ 47,065	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 2009 report.		\$	6,100	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.)	2009	\$	5,852	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(248)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,060	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	122	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	5,934	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	4,965	8
	2006	5,429	9
	2007	5,520	10
	2008	5,961	11
	2009	5,852	12

Accrual based on prior year tax bill.			
	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

Facility Name & ID Number Countryview Terrace

0046078 Report Period Beginning:

1/1/2010 Ending:

12/31/2010

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

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$ 248,394	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Survey		1996		1,700		20	85	85	1,247	9
10	Curtains		1996		307		20	15	15	218	10
11	Pump Repairs		1996		1,163		20	58	58	856	11
12	Repiping Water Heater		1996		1,681		20	84	84	1,225	12
13	Fence		1997		2,469		20	123	123	1,630	13
14	Plumbing		1997		1,234		20	62	62	847	14
15	Handicapped Showers & Ramp		1998		1,962		20	98	98	1,225	15
16	Landscaping		2000		4,289		20	214	214	2,247	16
17	Drainage and Sidewalk		2001		2,557		20	128	128	1,217	17
18	Roof		2001		8,701		20	435	435	4,133	18
19	Water Supply		2002		2,413		20	121	121	1,028	19
20	Roof		2004		900		20	45	45	293	20
21	Bathroom Sinks and Showers		2004		12,800		20	640	640	4,160	21
22	Furnace		2007		5,428		20	271	271	949	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					149			(149)		30
31	Building Booked					14,869			(14,869)		31
32	Building Improvement Booked					2,091			(2,091)		32
33											33
34	2010-Home Office Allocation-Building Improvements				2,215			53	53		34
35	2010-Home Office Allocation-Land Improvements				207			11	11		35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 629,915	\$ 17,109		\$ 19,011	\$ 1,902	\$ 269,669	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:

1/1/2010

Ending:

12/31/2010

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	\$ 1,171	\$ 529	\$ (642)	10 yrs.	\$ 1,767	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	43,492					43,492	73
74	Home Office Allocation			989	989			74
75	TOTALS	\$ 48,780	\$ 1,171	\$ 1,518	\$ 347		\$ 45,259	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)	\$ 698,681	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,280	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,529	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 324,914	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	N/A	\$	92
93			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: \$ 2,246 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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 1/1/2010
Period End 12/31/2010**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 2,128
Home Office Allocation	118
	<u>2,246</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	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1	
2	Licensed Speech and Language Development Therapist		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	39(2)	# of prescrpts				89		89	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			\$		\$	89		\$	89	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: 1/1/2010

Ending:

12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(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	\$ 1,142,683	\$ 1,142,683	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	21,171	21,171	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,177	4,177	6
7	Other Prepaid Expenses	10,420	10,420	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)	\$ 1,294,572	\$ 1,294,572	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	582,104	14
15	Leasehold Improvements, at Historical Cost	53,526	47,811	15
16	Equipment, at Historical Cost	58,765	58,766	16
17	Accumulated Depreciation (book methods)	(293,340)	(324,914)	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)	\$ 398,840	\$ 373,767	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,693,412	\$ 1,668,339	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 149,733	\$ 149,733	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,375	12,375	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,527	2,527	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,060	6,060	32
33	Accrued Interest Payable	4,039	4,039	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	5,541	5,541	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 180,275	\$ 180,275	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	829,038	829,038	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Accrued Fine</u>	22,750	22,750	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 851,788	\$ 851,788	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,032,063	\$ 1,032,063	46
47	TOTAL EQUITY(page 18, line 24)	\$ 661,349	\$ 636,276	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,693,412	\$ 1,668,339	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 710,538	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 710,540	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(49,191)	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)	\$ (49,191)	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)	\$ 661,349	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Countryview Terrace# 0046078Report Period Beginning: 1/1/2010Ending: 12/31/2010

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	\$ 449,506	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 449,506	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	25	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 449,531	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	87,322	31
32	Health Care	191,274	32
33	General Administration	94,301	33
B. Capital Expense			
34	Ownership	72,287	34
C. Ancillary Expense			
35	Special Cost Centers	25,250	35
36	Provider Participation Fee	28,288	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 498,722	40
41	Income before Income Taxes (line 30 minus line 40)**	(49,191)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (49,191)	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:

1/1/2010

Ending:

12/31/2010

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	15,173	15,691	131,474	8.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,534	2,671	24,196	9.06	10
11	Social Service Workers	2,170	2,170	23,196	10.69	11
12	Dietician					12
13	Food Service Supervisor	2,085	2,191	27,375	12.49	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	101	101	1,758	17.41	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	41,602	20.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,143	24,904	\$ 249,601 *	\$ 10.02	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	3,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	738	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>	20 visits	1,896	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,234		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	
Terri Mulvaney	Administrator	0	\$ 41,602	Workers' Compensation Insurance	\$ 6,287	IDPH License Fee	\$	
				Unemployment Compensation Insurance	4,606	Advertising: Employee Recruitment		
				FICA Taxes	15,678	Health Care Worker Background Check		
				Employee Health Insurance	(944)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	572	
				Employee Relations	418	Miscellaneous Dues & Subscriptions	20	
				Employee Retirement	131	IHCA Dues	0	
				Life Insurance	(133)	Home Office Allocation	236	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,602	TOTAL (agree to Schedule V, line 22, col.8)		\$ 828		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 50,000				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 50,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Wabash Telephone Cooperative	Computer Services	\$ 420			\$	Out-of-State Travel \$		
Clifton Gunderson	Accounting Services	3,000						
						In-State Travel		
						Seminar Expense		
						Home Office Allocation 7		
						Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,420	TOTAL		\$ 7		

* Attach copy of IMRF notifications

**See instructions.

Countryview Terrace

0046078

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		3,420

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	1
Healthcare Resources International	Legal	12
Ginoli & Company	Accountants	168
Bank of America	Accountants	37
Miscellaneous Vendors	Computer Services	4
VisionShare	Computer Services	51
Advanced Answers on Demand	Computer Services	318
Access 2 Go	Computer Services	52
Kemper Technology	Computer Services	44
MediFax	Computer Services	18
LogmeIn	Computer Services	13
Simple LTC	Computer Services	203
Optimizer Systems	Other Professional Fees	7
Clifton Gunderson	Other Professional Fees	23
Total (agree to Schedule V, line 19, column 8)		<u>4,371</u>

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? 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. \$ 843 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 28,288
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? N/A 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. \$ _____
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & 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.