



Facility Name & ID Number Countryview Terrace

# 0053041 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS			3,204	3,204	13
14	TOTALS			3,204	3,204	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.86%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 2/10/1996

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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Countryview Terrace # 0053041 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	29,881	1,644		31,525		31,525	719	32,244		1
2	Food Purchase		14,395		14,395		14,395	3	14,398		2
3	Housekeeping		3,152		3,152		3,152	11	3,163		3
4	Laundry										4
5	Heat and Other Utilities			10,145	10,145		10,145	38	10,183		5
6	Maintenance		3,255	10,147	13,402		13,402	340	13,742		6
7	Other (specify):* Home Office Ben. Allocation										7
8	<b>TOTAL General Services</b>	29,881	22,446	20,292	72,619		72,619	1,111	73,730		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	168,254	4,581	1,804	174,639		174,639	(129)	174,510		10
10a	Therapy										10a
11	Activities		782	702	1,484		1,484		1,484		11
12	Social Services	21,703			21,703		21,703	(2,799)	18,904		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	<b>TOTAL Health Care and Programs</b>	189,957	5,363	6,106	201,426		201,426	(2,928)	198,498		16
	<b>C. General Administration</b>										
17	Administrative			64,600	64,600		64,600	(22,474)	42,126		17
18	Directors Fees										18
19	Professional Services			7,250	7,250		7,250	7,224	14,474		19
20	Dues, Fees, Subscriptions & Promotions			4,967	4,967		4,967	17	4,984		20
21	Clerical & General Office Expenses		974	7,102	8,076		8,076	7,741	15,817		21
22	Employee Benefits & Payroll Taxes			28,043	28,043		28,043	3,482	31,525		22
23	Inservice Training & Education			250	250		250	21	271		23
24	Travel and Seminar							11	11		24
25	Other Admin. Staff Transportation			8,204	8,204		8,204	515	8,719		25
26	Insurance-Prop.Liab.Malpractice			7,397	7,397		7,397	137	7,534		26
27	Other (specify):* Home Office Ben. Allocation										27
28	<b>TOTAL General Administration</b>		974	127,813	128,787		128,787	(3,326)	125,461		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	219,838	28,783	154,211	402,832		402,832	(5,143)	397,689		29

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

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

Facility Name &amp; ID Number

Countryview Terrace

#0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			19,839	19,839		19,839	5,008	24,847			30
31	Amortization of Pre-Op. & Org.							17	17			31
32	Interest							1,390	1,390			32
33	Real Estate Taxes			6,217	6,217		6,217	41	6,258			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			665	665		665	219	884			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			26,721	26,721		26,721	6,675	33,396			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			17,155	17,155		17,155		17,155			42
43	Other (specify):*		260	12,795	13,055		13,055	(13,055)				43
44	<b>TOTAL Special Cost Centers</b>		260	29,950	30,210		30,210	(13,055)	17,155			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	219,838	29,043	210,882	459,763		459,763	(11,523)	448,240			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# 0053041

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	\$ (2,799)	11	1
2	Disallowed Special Events	(480)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(139)	10	3
4				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	<b>Total</b>	(3,418)		49

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 719	\$ 719	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	3	3	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	11	11	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	38	38	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	340	340	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	10	10	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	64,600	Petersen Health Care Management, Inc.	100.00%	42,126	(22,474)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	2,253	2,253	12
13	V							13
14	Total		\$ 64,600			\$ 45,500	\$ * (19,100)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 17	\$	17	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	7,741		7,741	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	3,482		3,482	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	21		21	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	11		11	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	515		515	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	137		137	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	1,844		1,844	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	17		17	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	60		60	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	41		41	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	219		219	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		\$			\$ 14,105	\$ *	14,105	39

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

Facility Name &amp; ID Number

Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name &amp; ID Number

Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name &amp; ID Number

Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30



Facility Name &amp; ID Number

Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

# 0053041

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Management, 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	1,451,714	75	\$ 325,901	\$ 376,129	3,204	\$ 719	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	3,204	3	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	3,204	11	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	3,204	38	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	3,204	340	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	3,204	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	3,204	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	3,204	10	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	3,204	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	3,204	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	3,204	42,126	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	3,204	2,253	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	3,204	17	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	3,204	7,741	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	3,204	3,482	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	3,204	21	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	3,204	11	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	3,204	515	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	3,204	137	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	3,204	1,844	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	3,204	17	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	3,204	60	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	3,204	41	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	3,204	219	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 59,605	25

Facility Name & ID Number Countryview Terrace# 0053041

Report Period Beginning:

1/1/2017Ending: 2/31/2017

## 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 Quality, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	83,607	9	\$	\$	3,204	\$	1
2	2	Food	Resident Days	83,607	9			3,204		2
3	3	Housekeeping	Resident Days	83,607	9			3,204		3
4	4	Laundry	Resident Days	83,607	9			3,204		4
5	5	Utilities	Resident Days	83,607	9			3,204		5
6	6	Maintenance	Resident Days	83,607	9			3,204		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,607	9			3,204		7
8	10	Nursing and Medical Records	Resident Days	83,607	9			3,204		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,607	9			3,204		9
10	17	Administrative	Resident Days	83,607	9			3,204		10
11	19	Professional Services	Resident Days	83,607	9			3,204		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,607	9			3,204		12
13	21	Clerical and General Office	Resident Days	83,607	9			3,204		13
14	22	Employee Benefits & Payroll	Resident Days	83,607	9			3,204		14
15	23	Inservice Training & Education	Resident Days	83,607	9			3,204		15
16	24	Travel and Seminar	Resident Days	83,607	9			3,204		16
17	25	Other Admin. Staff Transport.	Resident Days	83,607	9			3,204		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,607	9			3,204		18
19	30	Depreciation	Resident Days	83,607	9			3,204		19
20	31	Amortization	Resident Days	83,607	9			3,204		20
21	32	Interest	Resident Days	83,607	9			3,204		21
22	33	Real Estate Taxes	Resident Days	83,607	9			3,204		22
23	34	Rent-Facility and Grounds	Resident Days	83,607	9			3,204		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,607	9			3,204		24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number

Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1										\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	1,390	14						
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	1,390	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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 2016 report.		\$	<u>6,600</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>6,313</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(287)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>6,504</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<u>41</u>	
<b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>6,258</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>6,139</u>	8
	2013	<u>6,275</u>	9
	2014	<u>6,302</u>	10
	2015	<u>6,404</u>	11
	2016	<u>6,313</u>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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: 246,000 2. Number of Years Over Which it is Being Amortized: 20  
3. Current Period Amortization: 17 4. Dates Incurred: 2013-2014

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 34,053	\$ 347,802	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Land Survey	1996		1,700		20			1,700	9
10		Curtains	1996		307		20			307	10
11		Pump Repairs	1996		1,163		20			1,163	11
12		Repiping Water Heater	1996		1,681		20			1,681	12
13		Fence	1997		2,469		20	101	101	2,469	13
14		Plumbing	1997		1,234		20	15	15	1,234	14
15		Handicapped Showers & Ramp	1998		1,962		20	98	98	1,911	15
16		Landscaping	2000		4,289		20	214	214	3,745	16
17		Drainage and Sidewalk	2001		2,557		20	128	128	2,113	17
18		Roof	2001		8,701		20	435	435	7,178	18
19		Water Supply	2002		2,413		20	121	121	1,875	19
20		Roof	2004		900		20	45	45	608	20
21		Bathroom Sinks and Showers	2004		12,800		20	640	640	8,640	21
22		Furnace	2007		5,428		20	271	271	2,846	22
23		Roof-Garage	2011		11,003		15	734	734	4,771	23
24		Phone System Replacement	2014		8,673		7	1,239	1,239	4,337	24
25		Shower Installation in Rooms 6 & 8	2014		6,357		15	424	424	1,484	25
26		Water Heater	2016		4,054		7	580	580	870	26
27		Shower Installation in Rooms 5	2016		4,000		15	266	266	399	27
28		Shower Room Install-Room 4	2017		4,575		7	327	327	327	28
29											29
30											30
31		Building Booked				14,869			(14,869)		31
32		Building Improvement Booked				4,267			(4,267)		32
33											33
34		2017-Home Office Allocation-Building Improvements			1,466			35	35		34
35		2017-Home Office Allocation-Land Improvements			135			9	9		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 and Improvement Costs-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)	\$ 667,756	\$ 19,136		\$ 22,250	\$ 20,599	\$ 397,460	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 9,646	\$ 703	\$ 797	\$ 94	5-10 yrs.	\$ 5,888	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	8,680					8,680	73
74	Home Office Allocation			1,800	1,800			74
75	TOTALS	\$ 18,326	\$ 703	\$ 2,597	\$ 1,894		\$ 14,568	75

D. Vehicle Costs. (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)	\$ 706,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,839	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,847	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,008	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 422,014	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					88
89	N/A				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.

Facility Name & ID Number Countryview Terrace

# 0053041

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**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	<b>TOTAL</b>				\$			7

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 884

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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* 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**

**0053041**

**Period Beginning 1/1/2017**

**Period End 12/31/2017**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Copier	665
Home Office Allocation	<u>219</u>
	<u>884</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	N/A	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.

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (837,111)	\$ (837,111)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 16,799 )	92,826	92,826	3
4	Supply Inventory (priced at Cost )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,777	4,777	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (739,508)	\$ (739,508)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	579,889	581,355	14
15	Leasehold Improvements, at Historical Cost	78,020	86,401	15
16	Equipment, at Historical Cost	28,312	28,312	16
17	Accumulated Depreciation (book methods)	(386,925)	(422,014)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 313,465	\$ 284,054	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (426,043)	\$ (455,454)	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 46,766	\$ 46,766	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,443	12,443	30
31	Accrued Taxes Payable (excluding real estate taxes)	770	770	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,504	6,504	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	6,041	6,041	36
37	<u>Accrued Management Fees</u>	183,869	183,869	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 256,393	\$ 256,393	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 256,393	\$ 256,393	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (682,436)	\$ (711,847)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (426,043)	\$ (455,454)	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (549,539)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	961	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (548,578)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(133,858)	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)	\$ (133,858)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (682,436)	24 *

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

Facility Name &amp; ID Number Countryview Terrace

# 0053041

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 322,967	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 322,967	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	2,799	28
28a	<u>Miscellaneous Revenue</u>	139	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,938	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 325,905	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	72,619	31
32	Health Care	201,426	32
33	General Administration	128,787	33
<b>B. Capital Expense</b>			
34	Ownership	26,721	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	13,055	35
36	Provider Participation Fee	17,155	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 459,763	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(133,858)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (133,858)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 322,967	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 322,967	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* 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

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	2,000	2,169	20,681	9.53
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	2,003	2,129	21,703	10.19
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	1,980	2,190	29,881	13.64
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator	2,080	2,080	42,126	20.25
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)	16,271	16,711	147,573	8.83
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	24,334	25,279	\$ 261,964 *	\$ 10.36

\* 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	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 829	L10, C3	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 Consulta</u>	12 975	L10, C3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	12 \$ 5,404		49

**C. CONTRACT NURSES**

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



Countryview Terrace

0053041

Period Beginning

1/1/2017

Period End

12/31/2017

Schedule 21A

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		7,250
<b>Home Office Allocation</b>		
MusilloUnkenholt, LLC	Legal	26
Arnstein & Lehr	Legal	173
SB2	Legal	109
Miscellaneous	Legal	2
Miller Hall and Triggs	Legal	28
Smith Amundsen	Legal	11
Healthcare Resources International	Legal	19
Hunziker Law	Legal	0
Lexis Nexis	Legal	1
Baker Tilly Virchow Krause	Legal	97
Secretary of State	Legal	8
Gemino	Legal	7
CliftonLarsonAllen	Accounting	529
Ginoli & Co.	Accounting	668
Baker Tilly Virchow Krause	Accounting	19
Gemino	Accounting	297
Miscellaneous	Computer Services	13
Change Healthcare	Computer Services	1
360 Networks	Computer Services	6
Matrix Care	Computer Services	539
Stratus Networks	Computer Services	64
Kemper Technology	Computer Services	37
AT&T	Computer Services	1
Ability Network	Computer Services	40
CIAN	Computer Services	45
Comcast	Computer Services	3
CCH	Computer Services	2
Charter Communications	Computer Services	5
Allscripts	Computer Services	40
ATS	Computer Services	41
Citrix Systems	Computer Services	4
Optimizer	Other Prof Fees	7
Ankura	Other Prof Fees	116
David Budde	Other Prof Fees	5
Sargent Consulting	Other Prof Fees	2239
Alix Partners	Other Prof Fees	1994
Demonica Kemper	Other Prof Fees	5
Brad Barkley	Other Prof Fees	19
MPAC Healthcare	Other Prof Fees	3
Higgs Appraisal	Other Prof Fees	1
Alan Litwiller	Other Prof Fees	0
Total (agree to Schedule V, line 19, column 8)		<u>14,474</u>

Facility Name &amp; ID Number Countryview Terrace

# 0053041

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$500
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,002 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 17,155  
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. \$ \_\_\_\_\_
- (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. \$ 1,399  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
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? Yes  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 1,400
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees