

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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>7880</u></p> <p>Facility Name: <u>Country Health</u></p> <p>Address: <u>RR1 Box 14</u> <u>Gifford</u> <u>61847</u> Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: <u>217-568-7362</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1970</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input 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>David M Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input 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>1/1/2018</u> to <u>12/31/2018</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 style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David M Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP/CFO</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td>Fax # () _____</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) _____	(Date) _____		(Type or Print Name) <u>David M Underwood</u>			(Title) <u>EVP/CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Firm Name & Address) _____																																													
	(Telephone) () _____	Fax # () _____																																												

Facility Name & ID Number Country Health

7880 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 _____

	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	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	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	10,817	17,407	2,260	30,484	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,817	17,407	2,260	30,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.84%

D. How many bed reserve days during this year were paid by the Department? 0 (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 1970

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 89 and days of care provided 2,260

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Country Health # 7880 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	266,298	22,756		289,054		289,054		289,054		1
2	Food Purchase		226,232		226,232		226,232		226,232		2
3	Housekeeping	113,736	27,450		141,186		141,186		141,186		3
4	Laundry	53,462	12,582		66,044		66,044		66,044		4
5	Heat and Other Utilities			189,981	189,981		189,981		189,981		5
6	Maintenance	111,411	91,373	102,048	304,832		304,832		304,832		6
7	Other (specify):*										7
8	TOTAL General Services	544,907	380,393	292,029	1,217,329		1,217,329		1,217,329		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	2,099,304	145,759	7,564	2,252,627		2,252,627		2,252,627		10
10a	Therapy		226,180	29,666	255,846	(254,942)	904		904		10a
11	Activities	63,988	5,373		69,361		69,361		69,361		11
12	Social Services	41,028		3,384	44,412		44,412		44,412		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,204,320	377,312	56,214	2,637,846	(254,942)	2,382,904		2,382,904		16
	C. General Administration										
17	Administrative	91,638			91,638		91,638		91,638		17
18	Directors Fees										18
19	Professional Services			319,104	319,104		319,104	(14,551)	304,553		19
20	Dues, Fees, Subscriptions & Promotions			259,603	259,603	(222,870)	36,733	(23,574)	13,159		20
21	Clerical & General Office Expenses	218,702	15,784	9,506	243,992		243,992		243,992		21
22	Employee Benefits & Payroll Taxes			610,139	610,139		610,139		610,139		22
23	Inservice Training & Education			2,440	2,440		2,440		2,440		23
24	Travel and Seminar			6,336	6,336		6,336	(1,337)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			144,965	144,965		144,965		144,965		26
27	Other (specify):* Lost Resident Items			89,393	89,393		89,393	(89,208)	185		27
28	TOTAL General Administration	310,340	15,784	1,441,486	1,767,610	(222,870)	1,544,740	(128,670)	1,416,070		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,059,567	773,489	1,789,729	5,622,785	(477,812)	5,144,973	(128,670)	5,016,303		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.

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			351,062	351,062		351,062		351,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			218,709	218,709		218,709	(16,343)	202,366			32
33	Real Estate Taxes			204,879	204,879		204,879		204,879			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,134	38,134		38,134		38,134			35
36	Other (specify):*											36
37	TOTAL Ownership			812,784	812,784		812,784	(16,343)	796,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			431,603	431,603	254,942	686,545		686,545			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					222,870	222,870		222,870			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			431,603	431,603	477,812	909,415		909,415			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,059,567	773,489	3,034,116	6,867,172		6,867,172	(145,013)	6,722,159			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,343)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,208)			18
19	Entertainment	(1,337)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,551)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,000)			24
25	Fund Raising, Advertising and Promotional	(23,574)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,013)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (145,013)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Country Health

ID# 7880

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				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		0	30	22
23		(14,551)	19	23
24		(74,000)	27	24
25		(23,574)	20	25
26		(1,337)	24	26
27		(15,208)	27	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(128,670)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health

7880

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,551)	0	0	0	0	0	0	0	0	0	0	(14,551)	19
20	Fees, Subscriptions & Promotions	(23,574)	0	0	0	0	0	0	0	0	0	0	(23,574)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,337)	0	0	0	0	0	0	0	0	0	0	(1,337)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(89,208)	0	0	0	0	0	0	0	0	0	0	(89,208)	27
28	TOTAL General Administration	(128,670)	0	0	0	0	0	0	0	0	0	0	(128,670)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(128,670)	0	0	0	0	0	0	0	0	0	0	(128,670)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Country Health

7880

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,343)	0	0	0	0	0	0	0	0	0	0	(16,343)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,343)	0	0	0	0	0	0	0	0	0	0	(16,343)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(145,013)	0	0	0	0	0	0	0	0	0	0	(145,013)	45

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
Board of Directors List Attached (Not for profit Board-No individual ownership)				Pleasant View Inc	Gifford	IL Apts

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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	Board Members are not compensated								\$	1
2	for their services									2
3										3
4										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 Country Health # 7880 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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
2									2
3									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	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	United Community		x				\$	\$ 4,861,717		\$ 218,709	1									
2											2									
3	EIEC		x					152,702			3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 5,014,419		\$ 218,709	9									
B. Non-Facility Related*																				
10	Interest Income									(16,343)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (16,343)	14									
15	TOTALS (line 9+line14)						\$	\$ 5,014,419		\$ 202,366	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* 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 2017 report.	\$	<u>203,042</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>198,986</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(4,056)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>208,935</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. (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.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>204,879</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>311,628</u>	8
	2014	<u>316,016</u>	9
	2015	<u>226,156</u>	10
	2016	<u>235,792</u>	11
	2017	<u>242,666</u>	12

Paid taxes included a \$30 special assessment from Champaign County for drainage projects.
Real estate tax accrual is calculated at 5% above the tax bill paid during the current year.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Health COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 7880

CONTACT PERSON REGARDING THIS REPORT David Underwood

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>110436300003</u>	_____	\$ <u>242,665.56</u>	\$ <u>198,986.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>242,665.56</u></u>	\$ <u><u>198,986.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

Pleasant View Apartments - common ownership - 14 independent living units - 12,138 square feet

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			1977	\$ 437,500	1
2					2
3	TOTALS			\$ 437,500	3

Facility Name & ID Number Country Health

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,933,545	\$ 278,125		\$ 278,125	\$	\$	70

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

Facility Name & ID Number Country Health

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,933,545	\$ 278,125		\$ 278,125	\$	\$	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	Ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,059,753	\$ 278,125		\$ 278,125	\$	\$	34

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

Facility Name & ID Number Country Health

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,059,753	\$ 278,125		\$ 278,125	\$	\$	1
2									2
3		2005	696						3
4		2005	9,840						4
5		2005	741						5
6		2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	683						22
23	Landscaping	2006	2,375						23
24	Sewage Grinder	2006	1,419						24
25	Sidewalk	2006							25
26	Fire Door	2006	4,228						26
27	Resident Room Remodel-- Flooring, paint	2006	1,411						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,205,295	\$ 278,125		\$ 278,125	\$	\$	34

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

Facility Name & ID Number Country Health

7880

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,205,295	\$ 278,125		\$ 278,125	\$	\$	1
2									2
3	1/2 hp Auto Door Opener	2007	750						3
4	Water Heater	2007	6517						4
5	Roof Repair	2007	851						5
6	Water Main	2007	1462						6
7	Fire System	2007	1662						7
8	Boiler	2007	1044						8
9	Breakers	2007	1393						9
10	Water Softener	2007	1382						10
11									11
12	HVAC Units	2008	3627						12
13	Mixing Valve	2008	8834						13
14	Circulator Pump	2008	2869						14
15									15
16	Water Heater	2009	2860						16
17	Fire Door	2009	4245						17
18									18
19	Water Main	2011	5000						19
20									20
21	Landscapping	2012	18565						21
22	Drywall - Paint & touch-up	2012	3716						22
23	HVAC Compressors	2012	7,500						23
24	Renovation - Contracted Total	2012	6,858,714						24
25	Renovation - Capitalized Interest	2012	673,048						25
26	Renovation - Additional Third Party Costs	2012							26
27	Asbestos	2012	444,405						27
28	Professional Fees	2012	776,516						28
29	Technology	2012	258,985						29
30	Other - Flooring, Drywall Window Treatments	2012	56,856						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,346,096	\$ 278,125		\$ 278,125	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,346,096	\$ 278,125		\$ 278,125	\$	\$	1
2									2
3	Kitchen Booster Heater	2013	2,781						3
4	Fire Alarm System Module	2013	3,111						4
5	Courtyard Landscaping	2013	2,697						5
6									6
7	Replaced (2) Chiller Motors	2014	2,530						7
8									8
9	Replace Bathroom Flooring	2015	3,362						9
10	Replace Walk-In Cooler	2015	4,096						10
11									11
12	Replace Chiller Compressor	2016	10,853						12
13									13
14	Installed 5 Ton A/C Unit	2017	3,279						14
15	Replaced Parking Lot Surface	2017	16,982						15
16	Re-Routed Water Lines	2017	9,910						16
17									17
18	Replace dry pendant fire sprinkler heads	2018	14,277						18
19	Install new concrete pad-entrance area	2018	3,000						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	TOTAL (lines 1 thru 33)		\$ 11,422,974	\$ 278,125		\$ 278,125	\$	\$	34

**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	\$ 1,406,806	\$ 70,041	\$ 70,041	\$		\$	71
72	Current Year Purchases	114,907						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,521,713	\$ 70,041	\$ 70,041	\$		\$	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	Maintenance	2011 Chevy Silverado	2016	\$ 20,271	\$ 2,896	\$ 2,896	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 20,271	\$ 2,896	\$ 2,896	\$		\$	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)	\$ 13,402,458	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 351,062	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 351,062	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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: None

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

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.	<u> </u>	<u>/2019</u>	\$ <u> </u>
13.	<u> </u>	<u>/2020</u>	\$ <u> </u>
14.	<u> </u>	<u>/2021</u>	\$ <u> </u>

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: \$ 38,134 Description: Office equipment & Televisions

(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	TOTAL		\$	\$	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.

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 checked="" type="checkbox"/> YES <input 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. 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	170,740	\$		\$	170,740	1
2	Licensed Speech and Language Development Therapist		hrs				35,665				35,665	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				225,198		904		226,102	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						225,276		225,276	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						29,666				29,666	13
14	TOTAL			\$		\$	461,269	\$	226,180	\$	687,449	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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,135,365	\$	1
2	Cash-Patient Deposits	6,370		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	677,345		3
4	Supply Inventory (priced at <u>FIFO</u>)	28,589		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,423		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	101,570		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,973,662	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	680,148		13
14	Buildings, at Historical Cost	11,328,692		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,541,984		16
17	Accumulated Depreciation (book methods)	(5,123,385)		17
18	Deferred Charges	2,182		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)	\$ 8,429,621	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,403,283	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 373,684	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,370		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,895		30
31	Accrued Taxes Payable (excluding real estate taxes)	(27)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	208,935		32
33	Accrued Interest Payable	17,219		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Bed Tax</u>	14,246		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 936,322	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,014,419		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,014,419	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,950,741	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,452,542	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,403,283	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,212,872	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,212,871	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	239,671	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)	\$ 239,671	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)	\$ 5,452,542	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,758,153	1
2	Discounts and Allowances for all Levels	(1,801,635)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,956,518	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,700,699	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,700,699	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	396,990	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,852	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 410,842	23
D. Non-Operating Revenue			
24	Contributions	22,421	24
25	Interest and Other Investment Income***	16,363	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 38,784	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,106,843	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,217,329	31
32	Health Care	2,637,846	32
33	General Administration	1,767,610	33
B. Capital Expense			
34	Ownership	812,784	34
C. Ancillary Expense			
35	Special Cost Centers	431,603	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,867,172	40
41	Income before Income Taxes (line 30 minus line 40)**	239,671	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 239,671	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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 Country Health

7880

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	1,483	1,578	\$ 63,777	\$ 40.42	1
2	Assistant Director of Nursing	2,071	2,203	67,888	30.82	2
3	Registered Nurses	13,407	14,263	461,084	32.33	3
4	Licensed Practical Nurses	20,176	21,464	580,275	27.03	4
5	CNAs & Orderlies	55,186	58,708	926,280	15.78	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	4,481	4,768	63,988	13.42	10
11	Social Service Workers	1,858	1,976	41,028	20.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,797	21,060	266,298	12.64	15
16	Dishwashers					16
17	Maintenance Workers	6,458	6,871	111,411	16.21	17
18	Housekeepers	9,123	9,705	113,736	11.72	18
19	Laundry	4,542	4,832	53,462	11.06	19
20	Administrator	1,955	2,080	91,638	44.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,988	9,561	218,702	22.87	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)	149,525	159,069	\$ 3,059,567 *	\$ 19.23	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		\$ 0		35
36	Medical Director		15,600		36
37	Medical Records Consultant		2,000		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,340		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		3,384		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,324		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		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		
Jason Grill			\$ 91,638	Workers' Compensation Insurance	\$ 62,203	IDPH License Fee	\$		
				Unemployment Compensation Insurance	(3,086)	Advertising: Employee Recruitment	6,289		
				FICA Taxes	234,057	Health Care Worker Background Check (Indicate # of checks performed)	1,500		
				Employee Health Insurance	299,008	Patient Background Checks			
				Employee Meals		PR	7,679		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	4,184		
				Other Benefits	17,957	License & Fees	3,655		
						Less: Public Relations Expense	(7,679)		
						Non-allowable advertising	(2,469)		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,638	TOTAL (agree to Schedule V, line 22, col.8)	\$ 610,139	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,159		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$ 0			\$	Out-of-State Travel	\$	
							In-State Travel		
								3,912	
								28	
							Seminar Expense	2,396	
								(1,337)	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999	
C. Professional Services									
Vendor/Payee	Type		Amount						
Heritage Operations Group	Mgmt		\$ 291,733						
MCK & Co	Audit		8,750						
Principal	401 k Mgmt		1,600						
Meyer Capel	Tax Review		1,500						
McKee Environmental	Annual review		970						
Legal adj to Zero			14,551						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 319,104						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Country Health

7880

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

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. Health Care Council of Illinois
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? _____
- (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. \$ 5,000 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. _____
- (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. \$ 222,870
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ 1,001
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Y
Firm Name: Pehlman & Dold PC
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

**Country Health
2018 Cost Report
Supplemental Schedules
Reclassification Entries**

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 225,276
Purchased Hospital Services	5,703
Purchased Laboratory Services	13,235
Purchased Radiology Services	10,728
Amount Reclassified to Line 39	<u>\$ 254,942</u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (48,728)
Provider Assesment Fee - \$6.07	<u>(174,142)</u>
	<u>(222,870)</u>
Provider Participation Fee	<u>222,870</u>