

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0007880

Facility Name: Country Health

Address: 2304 C R 3000 N Bx14 Gifford 61847
Number City Zip Code

County: Champaign

Telephone Number: 217-568-7362 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Dave Underwood Telephone Number: 309 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

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

Facility Name & ID NumberCountry Health

#0007880Report Period Beginning:01/01/16Ending:12/31/16

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	32,574	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	32,574	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,097	18,693	2,417	30,207	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,097	18,693	2,417	30,207	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)92.73%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YESNOX

I. On what date did you start providing long term care at this location?
Date started1970

J. Was the facility purchased or leased after January 1, 1978?
YESDateNONOX

K. Was the facility certified for Medicare during the reporting year?
YESXNONOXIf YES, enter number of beds certifiedand days of care provided2,417

Medicare IntermediaryWPS

IV. ACCOUNTING BASIS

MODIFIED
ACCRUALX
CASH*
CASH*

Is your fiscal year identical to your tax year?YESXNONOX

Tax Year:Fiscal Year:

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	231,170	18,722		249,892		249,892		249,892			1
2	Food Purchase		238,386		238,386		238,386		238,386			2
3	Housekeeping	94,225	28,910		123,135		123,135		123,135			3
4	Laundry	67,342	10,202		77,544		77,544		77,544			4
5	Heat and Other Utilities			192,640	192,640		192,640		192,640			5
6	Maintenance	87,050	73,903	71,117	232,070		232,070		232,070			6
7	Other (specify):*											7
8	TOTAL General Services	479,787	370,123	263,757	1,113,667		1,113,667		1,113,667			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,995,686	142,134	9,863	2,147,683		2,147,683		2,147,683			10
10a	Therapy		235,503	31,565	267,068	(266,588)	480		480			10a
11	Activities	63,405	3,271		66,676		66,676		66,676			11
12	Social Services	37,918		3,021	40,939		40,939		40,939			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,097,009	380,908	57,649	2,535,566	(266,588)	2,268,978		2,268,978			16
	C. General Administration											
17	Administrative	86,688			86,688		86,688		86,688			17
18	Directors Fees											18
19	Professional Services			242,738	242,738		242,738	(8,889)	233,849			19
20	Dues, Fees, Subscriptions & Promotions			245,809	245,809	(218,863)	26,946	(16,484)	10,462			20
21	Clerical & General Office Expenses	204,753	20,520	7,354	232,627		232,627		232,627			21
22	Employee Benefits & Payroll Taxes			666,566	666,566		666,566		666,566			22
23	Inservice Training & Education			7,750	7,750		7,750		7,750			23
24	Travel and Seminar			6,788	6,788		6,788	(1,789)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			141,408	141,408		141,408		141,408			26
27	Other (specify):*			41,319	41,319		41,319	(41,319)				27
28	TOTAL General Administration	291,441	20,520	1,359,732	1,671,693	(218,863)	1,452,830	(68,481)	1,384,349			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,868,237	771,551	1,681,138	5,320,926	(485,451)	4,835,475	(68,481)	4,766,994			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			363,363	363,363		363,363		363,363			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			242,162	242,162		242,162	(13,615)	228,547			32
33	Real Estate Taxes			194,720	194,720		194,720		194,720			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,470	24,470		24,470		24,470			35
36	Other (specify):*											36
37	TOTAL Ownership			824,715	824,715		824,715	(13,615)	811,100			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			457,423	457,423	266,588	724,011		724,011			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					218,863	218,863		218,863			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			457,423	457,423	485,451	942,874		942,874			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,868,237	771,551	2,963,276	6,603,064		6,603,064	(82,096)	6,520,968			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(13,615)			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				18
19	Entertainment	(1,789)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,889)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,319)			24
25	Fund Raising, Advertising and Promotional	(16,484)			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)	\$ (82,096)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (82,096)		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 Yes	2 No	3 Amount	4 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

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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(8,889)	19	22
23				23
24		(41,319)	27	24
25		(16,484)	20	25
26				26
27		0	22	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	(66,692)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(8,889)	0	0	0	0	0	0	0	0	0	0	(8,889)	19
20	Fees, Subscriptions & Promotions	(16,484)	0	0	0	0	0	0	0	0	0	0	(16,484)	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	(1,789)	0	0	0	0	0	0	0	0	0	0	(1,789)	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):*	(41,319)	0	0	0	0	0	0	0	0	0	0	(41,319)	27
28	TOTAL General Administration	(68,481)	0	0	0	0	0	0	0	0	0	0	(68,481)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(68,481)	0	0	0	0	0	0	0	0	0	0	(68,481)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(13,615)	0	0	0	0	0	0	0	0	0	0	(13,615)	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	(13,615)	0	0	0	0	0	0	0	0	0	0	(13,615)	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)	(82,096)	0	0	0	0	0	0	0	0	0	0	(82,096)	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
Not for Profit				Pleasant View	Gifford	Apartments
List of Board Members Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
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	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 # 0007880 Report Period Beginning: 01/01/16 Ending: 12/31/16

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						\$	6,019,238			\$ 242,162	1
2												2
3	EIEC							397,166				3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	6,416,404			\$ 242,162	9
	B. Non-Facility Related*											
10	Interest Income										(13,615)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (13,615)	14
15	TOTALS (line 9+line14)						\$	6,416,404			\$ 228,547	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	274,511	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.)				\$	228,470	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(46,041)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	196,453	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 \$ 44,308 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	44,308	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	194,720	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011		8		
		2012		9		
		2013	311,628	10		
		2014	316,016	11		
		2015	226,156	12		
Ending accrual balance is computed as follows:						
2015 taxes paid in 2016 per revised bill (\$226,156) times estimated inflation (5%) times the Country Health allocation (.8273).				13	FROM R. E. TAX STATEMENT FOR 2015 \$	13
Tax reduction documentation attached.				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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Country Health COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0007880

CONTACT PERSON REGARDING THIS REPORT David M Underwood

TELEPHONE 309 823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 110436300003		\$ 226,155.64	\$ 187,098.56
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 226,155.64	\$ 187,098.56

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? x 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

58,148

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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 27,031	1
2					2
3	TOTALS			\$ 27,031	3

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	89				\$ 744,720	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1976 Improvements		1976		10,703					9
10	1977 Improvements		1979		15,361					10
11	1978 Improvements		1977		25,766					11
12	1979 Improvements		1978		6,618					12
13	1980 Improvements		1980		30,846					13
14	1981 Improvements		1981		18,567					14
15	1982 Improvements		1982		4,662					15
16	1983 Improvements		1983		28,833					16
17	1984 Improvements		1984		6,700					17
18	1985 Improvements		1985		33,953					18
19	1986 Improvements		1986		23,775					19
20	1987 Improvements		1987		40,603					20
21	1988 Improvements		1988		163,565					21
22	1989 Improvements		1989		50,581					22
23	1990 Improvements		1990		111,695					23
24	1991 Improvements		1991		36,516					24
25	1992 Improvements		1992		26,816					25
26	1993 Improvements		1993		21,383					26
27	1994 Improvements		1994		12,384					27
28	1995 Improvements		1995		5,450					28
29	NURSE CALL SYSTEM		1996		6,349					29
30	DINNING ROOM EXPANSION		1996		10,109					30
31	Dinning Room Remodel		1997		6,121					31
32										32
33										33
34										34
35	Book Depreciation					297,948		297,948		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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 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)		\$ 1,891,513	\$ 297,948		\$ 297,948	\$	\$	70

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 1,891,513	\$ 297,948		\$ 297,948	\$	\$	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)		\$ 2,017,721	\$ 297,948		\$ 297,948	\$	\$	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 12B, Carried Forward		\$ 2,017,721	\$ 297,948		\$ 297,948	\$	\$	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	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	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,187,553	\$ 297,948		\$ 297,948	\$	\$	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
1 Totals from Page 12C, Carried Forward		\$ 2,187,553	\$ 297,948		\$ 297,948	\$	\$	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)		\$ 11,328,354	\$ 297,948		\$ 297,948	\$	\$	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
1 Totals from Page 12D, Carried Forward		\$ 11,328,354	\$ 297,948		\$ 297,948	\$	\$	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								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 TOTAL (lines 1 thru 33)		\$ 11,357,784	\$ 297,948		\$ 297,948	\$	\$	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	\$1,362,294	\$60,181	\$60,181	\$		\$	71
72	Current Year Purchases	13,279						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,375,573	\$60,181	\$60,181	\$		\$	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				\$	\$5,234	\$5,234	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$5,234	\$5,234	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$12,760,388	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$363,363	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$363,363	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

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: \$ 24,470 Description: Copiers and 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	None		\$	\$	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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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

	1	2	3	4	5	6	7	8		
	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	\$		\$ 180,637	\$		\$ 180,637	1
2	Licensed Speech and Language Development Therapist		hrs			25,989			25,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			250,797	480		251,277	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				235,023		235,023	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					31,565			31,565	13
14	TOTAL			\$		\$ 488,988	\$ 235,503		\$ 724,491	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,306,648	\$	1
2	Cash-Patient Deposits	12,023		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	722,604		3
4	Supply Inventory (priced at)	20,030		4
5	Short-Term Investments			5
6	Prepaid Insurance	29,084		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	17,301		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,107,690	\$	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	11,281,244		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,417,967		16
17	Accumulated Depreciation (book methods)	(4,406,385)		17
18	Deferred Charges	7,250		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)	\$ 8,980,224	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,087,914	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 256,385	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,023		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	279,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	814		31
32	Accrued Real Estate Taxes(Sch.IX-B)	237,463		32
33	Accrued Interest Payable	18,810		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	28,972		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 833,945	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,416,404		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)	\$ 6,416,404	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,250,349	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,837,565	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,087,914	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,381,098	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,381,098	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	456,467	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)	\$ 456,467	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)	\$ 4,837,565	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 6,631,830	1
2	Discounts and Allowances for all Levels	(1,972,354)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,659,476	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,796,680	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,796,680	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	389,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,398	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 412,147	23
	D. Non-Operating Revenue		
24	Contributions	177,613	24
25	Interest and Other Investment Income***	13,615	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 191,228	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)	\$ 7,059,531	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,113,667	31
32	Health Care	2,535,566	32
33	General Administration	1,671,693	33
	B. Capital Expense		
34	Ownership	824,715	34
	C. Ancillary Expense		
35	Special Cost Centers	457,423	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)*	\$ 6,603,064	40
41	Income before Income Taxes (line 30 minus line 40)**	456,467	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 456,467	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.

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	1,877	1,976	\$ 73,733	\$ 37.31	1
2	Assistant Director of Nursing	3,096	3,259	90,378	27.73	2
3	Registered Nurses	12,828	13,503	418,945	31.03	3
4	Licensed Practical Nurses	20,499	21,578	534,171	24.76	4
5	CNAs & Orderlies	59,090	62,200	878,459	14.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	4,671	4,917	63,405	12.90	10
11	Social Service Workers	1,859	1,957	37,918	19.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,873	19,866	231,170	11.64	15
16	Dishwashers					16
17	Maintenance Workers	5,700	6,000	87,050	14.51	17
18	Housekeepers	8,353	8,793	94,225	10.72	18
19	Laundry	5,621	5,917	67,342	11.38	19
20	Administrator	1,984	2,088	86,688	41.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,566	9,017	204,753	22.71	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)	153,017	161,071	\$ 2,868,237 *	\$ 17.81	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		13,200		36
37	Medical Records Consultant		2,440		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		3,021		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,001		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 1,063	L10 C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 1,063		53

Facility Name & ID Number		Country Health	STATE OF ILLINOIS		Report Period Beginning:		01/01/16	Page 21	
			# 0007880		Ending:		12/31/16		
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			\$ 86,688	Workers' Compensation Insurance	\$ 54,426		IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,429		Advertising: Employee Recruitment	1,441	
				FICA Taxes	219,420		Health Care Worker Background Check		
				Employee Health Insurance	380,531		(Indicate # of checks performed)	1,950	
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
							PR	4,772	
				Other Benefits	10,760		Dues & Subscriptions	6,571	
							License & Fees	4,469	
							Less: Public Relations Expense	(4,772)	
							Non-allowable advertising	(3,969)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 86,688	TOTAL (agree to Schedule V, line 22, col.8)		\$ 666,566	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,462
(List each licensed administrator separately.)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
B. Administrative - Other									
Description			Amount	Description			Amount		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount		Line #					
Heritage Operations Group	Mgmt	\$ 216,127					Out-of-State Travel		
Sulaski & Webb	Audit	8,700					\$		
ADP	Payroll tax processing	1,198							
Principal	401 k Mgmt	1,600							
Meyer Capel	Property Tax appeal	4,942					In-State Travel		
Allen & Korkowski	Consulting	432							
MPRO	Peer review	850					3,650		
							40		
							Seminar Expense		
							3,098		
							(1,789)		
Legal adj to Zero		8,889					Entertainment Expense		
							()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 242,738	TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)							TOTAL		
							\$ 4,999		
				* Attach copy of IMRF notifications			**See instructions.		

Facility Name & ID Number Country Health STATE OF ILLINOIS # 0007880 Report Period Beginning: 01/01/16 Ending: 12/31/16	Page 22
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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. HCCI

(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. \$ 218,863
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? Yes Indicate the amount. \$ 1,322

(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? Yes
Firm Name: Sulaski & Webb

(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. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Mason City Are Nursing Home
HFS ID# 371168043001
HFS Cost Report - December 31, 2016
Board of Directors

<u>Member</u>	<u>Home City</u>	<u>State</u>
Reverend Jim Sprinke	Mason City	IL
Robert Griffin - Vice P	Mason City	IL
Karen Duckworth	Mason City	IL
Bonnie Dunker	Mason City	IL
Kraig Kruse	Easton	IL
Suzanne Lowers	Easton	IL
Kate Nunn	Easton	IL
Dan Shepherd	San Jose	IL

Country Health
HFS ID# 376064916001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

Add (Subtract)

Reclassification of Provider Participation Fees

Provider Participation Fee - \$1.50	Line 20, Col 3	(48,861)
Provider Assesment Fee - \$6.07	Line 20, Col 3	<u>(170,002)</u>
		<u>(218,863)</u>
Provider Participation Fee	Line 42	<u>218,863</u>

Reclassification of Ancillary Services Cost

Cost of Drugs Purchased	Line 10(a), Col 2	(235,023)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	<u>(31,565)</u>
		<u>(266,588)</u>
Ancillary Service Centers	Line 39	<u>266,588</u>