

		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: 0053199

Facility Name: Countryview Care Ctr Macomb

Address: 400 West Grant St Macomb 61455
Number City Zip Code

County: McDonough

Telephone Number: (309) 837-2386 Fax # (309) 836-9191

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

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

☒ 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: Mike Kocher Telephone Number: (309) 673-3009
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 1/1/2016 to 12/31/2016 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) _____ (Date) _____
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(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 NumberCountryview Care Ctr Macomb

#0053199Report Period Beginning:1/1/2016Ending:12/31/2016

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 bedsN/A

1	2	3	4		
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period		
1	16	Skilled (SNF)	16	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	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	369	1,205	405	1,979	8
9	SNF/PED					9
10	ICF	16,790			16,790	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,159	1,205	405	18,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)82.94%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNO[X]

I. On what date did you start providing long term care at this location?Date started10/1/2005

J. Was the facility purchased or leased after January 1, 1978?YES[X]Date10/1/2005NO

K. Was the facility certified for Medicare during the reporting year?YES[X]NOIf YES, enter number of beds certified16and days of care provided397

Medicare IntermediaryNational Government Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL[X]CASH* CASH*

Is your fiscal year identical to your tax year?YES[X]NO

Tax Year:12/31/2016Fiscal Year:12/31/2016

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0053199 Report Period Beginning: 1/1/2016 Ending: 12/31/2016
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	108,578	11,319		119,897		119,897	3,855	123,752			1
2	Food Purchase		118,852		118,852		118,852	(1,129)	117,723			2
3	Housekeeping	82,901	16,621		99,522		99,522	67	99,589			3
4	Laundry	42,867	9,030	30	51,927		51,927		51,927			4
5	Heat and Other Utilities			52,702	52,702		52,702	225	52,927			5
6	Maintenance	24,325	6,804	26,022	57,151		57,151	2,105	59,256			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	258,671	162,626	78,754	500,051		500,051	5,123	505,174			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	800,704	52,271	4,620	857,595		857,595	(57)	857,538			10
10a	Therapy		130	59,285	59,415		59,415		59,415			10a
11	Activities	49,578	151	149	49,878		49,878	(15,775)	34,103			11
12	Social Services	27,570	6		27,576		27,576		27,576			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	877,852	52,558	78,454	1,008,864		1,008,864	(15,832)	993,032			16
	C. General Administration											
17	Administrative			181,600	181,600		181,600	(106,725)	74,875			17
18	Directors Fees											18
19	Professional Services			5,951	5,951		5,951	18,959	24,910			19
20	Dues, Fees, Subscriptions & Promotions			4,877	4,877		4,877	(20)	4,857			20
21	Clerical & General Office Expenses	36,743	4,331	11,636	52,710		52,710	45,158	97,868			21
22	Employee Benefits & Payroll Taxes			149,345	149,345		149,345	25,131	174,476			22
23	Inservice Training & Education							86	86			23
24	Travel and Seminar							42	42			24
25	Other Admin. Staff Transportation			12,444	12,444		12,444	3,536	15,980			25
26	Insurance-Prop.Liab.Malpractice			17,251	17,251		17,251	15,095	32,346			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	36,743	4,331	383,104	424,178		424,178	1,262	425,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,173,266	219,515	540,312	1,933,093		1,933,093	(9,447)	1,923,646			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			28,435	28,435		28,435	36,058	64,493			30
31	Amortization of Pre-Op. & Org.							1,243	1,243			31
32	Interest			53,504	53,504		53,504	78,665	132,169			32
33	Real Estate Taxes			9,750	9,750		9,750	9,979	19,729			33
34	Rent-Facility & Grounds			112,951	112,951		112,951	(112,951)				34
35	Rent-Equipment & Vehicles			9,929	9,929		9,929	809	10,738			35
36	Other (specify):*											36
37	TOTAL Ownership			214,569	214,569		214,569	13,803	228,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,648		20,648		20,648		20,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,258	145,258		145,258		145,258			42
43	Other (specify):*	30,270	120	216,737	247,127		247,127	(247,127)				43
44	TOTAL Special Cost Centers	30,270	20,768	361,995	413,033		413,033	(247,127)	165,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,203,536	240,283	1,116,876	2,560,695		2,560,695	(242,771)	2,317,924			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	(1,199)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,231)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,326	30		9
10	Interest and Other Investment Income	(143)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	43		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	(138,281)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,200)	43		24
25	Fund Raising, Advertising and Promotional	(1,353)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(47,481)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (263,686)		\$	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)	20,915	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,915		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (242,771)		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	Labs-Part A	\$ (916)	43	1
2	Offset Miscellaneous Office Supplies Revenue	213	21	2
3	Disallowed Special Events	(131)	43	3
4	Offset Transportation Revenue	(15,775)	11	4
5	Disallowed Chamber of Commerce Dues	(431)	20	5
6	Disallowed Marketing Salaries	(30,270)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(171)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(47,481)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Care Ctr Macomb

0053199

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	3,855	0	0	0	0	0	0	0	0	0	3,855	1
2	Food Purchase	(1,199)	70	0	0	0	0	0	0	0	0	0	(1,129)	2
3	Housekeeping	0	67	0	0	0	0	0	0	0	0	0	67	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	225	0	0	0	0	0	0	0	0	0	225	5
6	Maintenance	0	2,105	0	0	0	0	0	0	0	0	0	2,105	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,199)	6,322	0	0	0	0	0	0	0	0	0	5,123	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	(171)	114	0	0	0	0	0	0	0	0	0	(57)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(15,775)	0	0	0	0	0	0	0	0	0	0	(15,775)	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	(15,946)	114	0	0	0	0	0	0	0	0	0	(15,832)	16
	C. General Administration													
17	Administrative	0	(106,725)	0	0	0	0	0	0	0	0	0	(106,725)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,818	0	9,141	0	0	0	0	0	0	0	18,959	19
20	Fees, Subscriptions & Promotions	(431)	0	411	0	0	0	0	0	0	0	0	(20)	20
21	Clerical & General Office Expenses	213	0	44,945	0	0	0	0	0	0	0	0	45,158	21
22	Employee Benefits & Payroll Taxes	0	0	25,131	0	0	0	0	0	0	0	0	25,131	22
23	Inservice Training & Education	0	0	86	0	0	0	0	0	0	0	0	86	23
24	Travel and Seminar	0	0	42	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	0	0	3,536	0	0	0	0	0	0	0	0	3,536	25
26	Insurance-Prop.Liab.Malpractice	0	0	498	0	14,597	0	0	0	0	0	0	15,095	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(218)	(96,907)	74,649	9,141	14,597	0	0	0	0	0	0	1,262	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,363)	(90,471)	74,649	9,141	14,597	0	0	0	0	0	0	(9,447)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Care Ctr Macomb # 0053199 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	1,326	0	9,946	0	24,786	0	0	0	0	0	0	36,058	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	1,243	0	0	0	0	0	0	1,243	31
32	Interest	(143)	0	292	34,154	44,362	0	0	0	0	0	0	78,665	32
33	Real Estate Taxes	0	0	229	0	9,750	0	0	0	0	0	0	9,979	33
34	Rent-Facility & Grounds	0	0	0	0	(112,951)	0	0	0	0	0	0	(112,951)	34
35	Rent-Equipment & Vehicles	0	0	809	0	0	0	0	0	0	0	0	809	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,183	0	11,276	34,154	(32,810)	0	0	0	0	0	0	13,803	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):*	(247,506)	0	0	0	379	0	0	0	0	0	0	(247,127)	43
44	TOTAL Special Cost Centers	(247,506)	0	0	0	379	0	0	0	0	0	0	(247,127)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(263,686)	(90,471)	85,925	43,295	(17,834)	0	0	0	0	0	0	(242,771)	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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

X 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	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,855	\$ 3,855	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	70	70	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	67	67	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	225	225	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,105	2,105	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	114	114	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	181,600	Petersen Health Care Management, Inc.	100.00%	74,875	(106,725)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	9,818	9,818	12
13	V								13
14	Total			\$ 181,600			\$ 91,129	\$ * (90,471)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 411	\$ 411	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	44,945	44,945	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,131	25,131	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	86	86	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	42	42	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,536	3,536	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	498	498	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,946	9,946	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	292	292	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	229	229	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	809	809	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 85,925	\$ * 85,925	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Properties, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Properties, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Properties, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Properties, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Properties, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Properties, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Properties, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Properties, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Properties, LLC	100.00%	9,141	9,141	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Properties, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Properties, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Properties, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Properties, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Properties, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Properties, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Properties, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Properties, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Properties, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Properties, LLC	100.00%	34,154	34,154	35
36	V	33	Real Estate Taxes		Petersen Health Properties, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Properties, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Properties, LLC	100.00%	0		38
39	Total			\$			\$ 43,295	\$ * 43,295	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance-Prop./Liab./Malprac.	\$	Countryview Care Center Land	100.00%	\$ 2,046	\$	2,046 15
16	V	26	Insurance-MIP		Countryview Care Center Land	100.00%	12,551		12,551 16
17	V	30	Depreciation		Countryview Care Center Land	100.00%	24,786		24,786 17
18	V	31	Amortization of Pre-Op. & Org.		Countryview Care Center Land	100.00%	1,243		1,243 18
19	V	32	Interest	144	Countryview Care Center Land	100.00%	44,506		44,362 19
20	V	33	Real Estate Taxes		Countryview Care Center Land	100.00%	9,750		9,750 20
21	V	34	Rent-Facility and Grounds	112,951	Countryview Care Center Land	100.00%			(112,951) 21
22	V	43	Service Charges-Banks		Countryview Care Center Land	100.00%	379		379 22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 113,095			\$ 95,261	\$ *	(17,834) 39

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

Facility Name & ID Number

Countryview Care Ctr Macomb

0053199

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Countryview Care Ctr Macomb

0053199

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Countryview Care Ctr Macomb

0053199

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Countryview Care Ctr Macomb # 0053199 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										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 Countryview Care Ctr Macomb# 0053199

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Mangagement, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	18,769	\$ 3,855	1
2	2	Food	Resident Days	75	5,673	0	18,769	70	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	18,769	67	3
4	5	Utilities	Resident Days	75	18,209	0	18,769	225	4
5	6	Maintenance	Resident Days	75	170,632	137,057	18,769	2,105	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,769	0	6
7	9	Medical Director	Resident Days	75	0	0	18,769	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	18,769	114	8
9	10A	Therapy	Resident Days	75	0	0	18,769	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,769	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	18,769	74,875	11
12	19	Professional Services	Resident Days	75	795,918	0	18,769	9,818	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	18,769	411	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	18,769	44,945	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	18,769	25,131	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	18,769	86	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	18,769	42	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	18,769	3,536	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	18,769	498	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,769	0	20
21	30	Depreciation	Resident Days	75	806,271	0	18,769	9,946	21
22	32	Interest	Resident Days	75	23,686	0	18,769	292	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	18,769	229	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	18,769	809	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 177,054	25

Facility Name & ID Number Countryview Care Ctr Macomb# 0053199

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Properties, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	62,883	3	\$	\$	18,769	\$	1
2	2	Food	Resident Days	62,883	3			18,769		2
3	3	Housekeeping	Resident Days	62,883	3			18,769		3
4	4	Laundry	Resident Days	62,883	3			18,769		4
5	5	Utilities	Resident Days	62,883	3			18,769		5
6	6	Maintenance	Resident Days	62,883	3			18,769		6
7	7	Mgmt. Allocation of Benefits	Resident Days	62,883	3			18,769		7
8	10	Nursing and Medical Records	Resident Days	62,883	3			18,769		8
9	15	Mgmt. Allocation of Benefits	Resident Days	62,883	3			18,769		9
10	17	Administrative	Resident Days	62,883	3			18,769		10
11	19	Professional Services	Resident Days	62,883	3	30,627		18,769	9,141	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	62,883	3			18,769		12
13	21	Clerical and General Office	Resident Days	62,883	3			18,769		13
14	22	Employee Benefits & Payroll	Resident Days	62,883	3			18,769		14
15	23	Inservice Training & Education	Resident Days	62,883	3			18,769		15
16	24	Travel and Seminar	Resident Days	62,883	3			18,769		16
17	25	Other Admin. Staff Transport.	Resident Days	62,883	3			18,769		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	62,883	3			18,769		18
19	30	Depreciation	Resident Days	62,883	3			18,769		19
20	31	Amortization	Resident Days	62,883	3			18,769		20
21	32	Interest	Resident Days	62,883	3	114,430		18,769	34,154	21
22	33	Real Estate Taxes	Resident Days	62,883	3			18,769		22
23	34	Rent-Facility and Grounds	Resident Days	62,883	3			18,769		23
24	35	Rent-Equipment & Vehicles	Resident Days	62,883	3			18,769		24
25	TOTALS					\$ 145,057	\$		\$ 43,295	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	Busey Bank		X	Mortgage	Varies	1/1/2015	2,160,000	\$ 2,144,582	12/31/2044	Varies	\$ 98,010	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,160,000	\$ 2,144,582			\$ 98,010	9
	B. Non-Facility Related*											
10								Interest Income Offset			(287)	10
11								Home Office Allocation-PHP			34,154	11
12								Home Office Allocation-PHCM			292	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 34,159	14
15	TOTALS (line 9+line14)						\$ 2,160,000	\$ 2,144,582			\$ 132,169	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

[illegible]

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 Countryview Care Ctr Maccomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0053199

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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) <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>11-400-806-00</u>	<u>Long-Term Care Facility</u>	\$ <u>19,452.10</u>	\$ <u>19,452.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>19,452.10</u></u>	\$ <u><u>19,452.10</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 X 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.

A. Square Feet:

12,290

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

74,585

2. Number of Years Over Which it is Being Amortized:

20

3. Current Period Amortization:

1,243

4. Dates Incurred:

2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	103,237		2005		\$ 58,500	
2							
3	TOTALS	103,237				\$ 58,500	

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	62		2005	1970	\$ 1,072,000	\$	25	\$ 43,280	\$ 43,280	\$ 497,720
5										
6										
7										
8										
	Improvement Type**									
9	Land Improvement		2006		15,000		15	1,000	1,000	10,500
10	Sprinkler System		2007		5,623		15			5,623
11	Countertop Installation		2009		4,183		15	278	278	2,085
12	A/C Unit		2009		6,031		7	428	428	6,031
13	Dry System Repair		2009		11,587		7	823	823	11,587
14	Sprinkler System Replacement		2009		13,900		15	926	926	6,945
15	Dry Pipe Valve Repair		2009		4,996		7			4,996
16	Dry System Replacement		2012		3,349		7	478	478	2,151
17	Cafeteria Door		2013		3,658		7	522	522	1,827
18	Landscaping Lighting		2013		9,592		15	640	640	2,240
19	Roof Replacement		2014		63,350		25	2,534	2,534	6,335
20	Roofing Repair		2016		2,950		7	211	211	211
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,000			(1,000)	
31	Building Booked					42,310			(42,310)	
32	Building Improvement Booked					7,971			(7,971)	
33										
34	2016-Home Office Allocation-Building Improvements				8,286			199	199	
35	2016-Home Office Allocation-Land Improvements				762			49	49	
36										

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

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

See Page 12A, Line 70 for total

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,225,267	\$ 51,281		\$ 51,368	\$ 87	\$ 558,251	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$34,264	\$1,940	\$3,427	\$1,487	5-10 yrs.	\$25,050	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	207,218					207,218	73
74	Home Office Allocation			9,698	9,698			74
75	TOTALS	\$241,482	\$1,940	\$13,125	\$11,185		\$232,268	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	Facility	Ford E-150 2007	2007	\$27,198	\$	\$	\$		\$27,198
77									
78									
79									
80	TOTALS			\$27,198	\$	\$	\$		\$27,198

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)			\$	1,552,447
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	53,221
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	64,493
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	11,272
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	817,717

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		\$	\$	
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy:
- ☐ YES
☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
☐ NO
16. Rental Amount for movable equipment: \$ 10,738
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Countryview Care Ctr Macomb
0053199

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,939
Dishwasher		709
Copier		4,281
Home Office Allocation		809
		<u>10,738</u>

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	10A(2), 10A(3)	hrs	\$	1,486	\$ 22,293	\$ 75	1,486	\$ 22,368	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		293	4,394		293	4,394	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,173	32,598	55	2,173	32,653	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				20,648		20,648	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,952	\$ 59,285	\$ 20,778	3,952	\$ 80,063	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	\$ (566,757)	\$ (566,757)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,253)	810,805	810,805	3
4	Supply Inventory (priced at Cost)	7,784	7,784	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,740	28,881	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		18,825	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 269,572	\$ 299,538	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		58,500	13
14	Buildings, at Historical Cost		1,080,286	14
15	Leasehold Improvements, at Historical Cost	66,300	144,981	15
16	Equipment, at Historical Cost	2,978	268,680	16
17	Accumulated Depreciation (book methods)	(7,876)	(817,717)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		73,342	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		239,771	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 61,402	\$ 1,047,843	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 330,974	\$ 1,347,381	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,949	\$ 290,949	26
27	Officer's Accounts Payable	500	500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,753	55,753	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,643	31,643	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,040	32
33	Accrued Interest Payable		7,309	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	17,926	17,926	36
37	Accrued Management Fees	66,159	66,159	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 462,930	\$ 490,279	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,144,582	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	174,644	171,745	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 174,644	\$ 2,316,327	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 637,574	\$ 2,806,606	46
47	TOTAL EQUITY(page 18, line 24)	\$ (306,600)	\$ (1,459,225)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 330,974	\$ 1,347,381	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 38,152	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(54,586)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (16,434)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(290,166)	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)	\$ (290,166)	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)	\$ (306,600)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Countryview Care Ctr Macomb

0053199

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 2,160,504	1
2	Discounts and Allowances for all Levels	(23,620)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,136,884	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,114	6
7	Oxygen	293	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 101,407	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	1,199	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,366	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,858	20
21	Other Medical Services	7,939	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,362	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	143	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 143	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	15,775	28
28a	<u>Miscellaneous Revenue</u>	(42)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,733	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,270,529	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	500,051	31
32	Health Care	1,008,864	32
33	General Administration	424,178	33
	B. Capital Expense		
34	Ownership	214,569	34
	C. Ancillary Expense		
35	Special Cost Centers	267,775	35
36	Provider Participation Fee	145,258	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,560,695	40
41	Income before Income Taxes (line 30 minus line 40)**	(290,166)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (290,166)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,948,586	44
45	Private Pay - Net Inpatient Revenue	135,777	45
46	Medicare - Net Inpatient Revenue	51,004	46
47	Other-(specify) <u>Insurance-Net Inpatient Revenue</u>	1,517	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,136,884	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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	1,828	1,852	\$ 56,414	\$ 30.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,377	4,533	121,484	26.80	3
4	Licensed Practical Nurses	10,593	11,051	197,657	17.89	4
5	CNAs & Orderlies	31,584	32,458	387,042	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	72	72	2,430	33.75	8
9	Activity Director	1,137	1,137	19,574	17.22	9
10	Activity Assistants	175	175	1,565	8.94	10
11	Social Service Workers	2,269	2,320	27,570	11.88	11
12	Dietician					12
13	Food Service Supervisor	1,806	1,903	26,426	13.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,697	9,794	82,152	8.39	15
16	Dishwashers					16
17	Maintenance Workers	1,761	1,850	24,325	13.15	17
18	Housekeepers	7,327	7,456	82,901	11.12	18
19	Laundry	4,783	5,001	42,867	8.57	19
20	Administrator	2,080	2,080	74,875	36.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,859	1,963	36,743	18.72	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	5,477	5,536	94,386	17.05	33
34	TOTAL (lines 1 - 33)	86,825	89,181	\$ 1,278,411 *	\$ 14.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	14,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,116	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,516		49

C. CONTRACT NURSES

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

Countryview Care Ctr Macomb
0053199
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,345	1,345	35,677	26.53
Transportation	2,288	2,347	28,439	12.12
Marketing	1,844	1,844	30,270	16.42
TOTAL	5,477	5,536	94,386	

STATE OF ILLINOIS

0053199

Report Period Beginning:

1/1/2016

Page 21

Ending: 12/31/2016

Facility Name & ID Number

Countryview Care Ctr Macomb

XIX. SUPPORT SCHEDULES

A. Administrative Salaries Name Function Ownership % Amount Jason Stewart Administrator 0 \$ 33,000 Kendel Brooks Administrator 0 26,125 Ashley Edmonds Administrator 0 15,750 TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$ 74,875			D. Employee Benefits and Payroll Taxes Description Amount Workers' Compensation Insurance \$ 20,981 Unemployment Compensation Insurance 34,892 FICA Taxes 88,480 Employee Health Insurance 3,355 Employee Meals Illinois Municipal Retirement Fund (IMRF)* Employee Relations 1,526 Employee Retirement 111 Home Office Allocation 25,131 TOTAL (agree to Schedule V, line 22, col.8) \$ 174,476			F. Dues, Fees, Subscriptions and Promotions Description Amount IDPH License Fee \$ Advertising: Employee Recruitment 833 Health Care Worker Background Check (Indicate # of checks performed 105) 1,317 Patient Background Checks 36 Miscellaneous Licenses & Permits 833 Miscellaneous Dues & Subscriptions 1,431 Home Office Allocation 411 Less: Public Relations Expense (431) Non-allowable advertising () Yellow page advertising () TOTAL (agree to Sch. V, line 20, col. 8) \$ 4,857		
B. Administrative - Other Description Amount Management Fees-See Page 6, Eliminated on P 3, C 7 \$ 181,600 TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) \$ 181,600			E. Schedule of Non-Cash Compensation Paid to Owners or Employees Description Line # Amount N/A TOTAL \$			G. Schedule of Travel and Seminar** Description Amount Out-of-State Travel \$ In-State Travel Seminar Expense Home Office Allocation 42 Entertainment Expense () TOTAL (agree to Sch. V, line 24, col. 8) \$ 42		
C. Professional Services Vendor/Payee Type Amount Logonix Corporation Computer Services \$ 587 E-Health Data Solutions Computer Services 2,941 Honkamp Krueger & Co. Accounting Fees 1,636 Lane and Watterman LLP Legal Fees-Lynch Case 276 Ability Network Computer Services 102 Comcast Computer Services 409 TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions) \$ 5,951			* Attach copy of IMRF notifications			**See instructions.		

HFS 3745 (N-4-99)

IL478-2471

Period Beginning	1/1/2016
Period End	12/31/2016

XIX. SUPPORT SCHEDULE

C. Professional Services

Home Office Allocation

Total (agree to Schedule V, line 19, column 8)	24,910
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XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>No</u> <u>IHCA \$1000</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>No</u> <u>N/A</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>7 yrs.</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>12,260</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> 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. This amount is to be recorded on line 42 of Schedule V.	\$ <u>145,258</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? (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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>1,199</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? 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? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> <u>Yes</u> <u>15,775</u> <u>100</u> <u>Adequate records have been maintained.</u> <u>Yes</u> <u>Yes</u> <u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>Ginoli and Company</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>N/A</u>

RECONCILIATION REPORT			Countryview Care Ctr N		09:49 AM		7/7/2017						
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-242,771	equal to	-242,771	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	132,169	equal to	132,169	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,729	equal to	19,729	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	1,243	equal to	1,243	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,493	equal to	64,493	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	10,738	equal to	10,738	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	59,415	equal to	59,415	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	20,778	equal to	20,778	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	500,051	equal to	500,051	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,008,864	equal to	1,008,864	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	424,178	equal to	424,178	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	214,569	equal to	214,569	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	267,775	equal to	267,775	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	145,258	equal to	145,258	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	800,704	equal to	800,704	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	49,578	equal to	49,578	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	27,570	equal to	27,570	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	108,578	equal to	108,578	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	24,325	equal to	24,325	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	82,901	equal to	82,901	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	42,867	equal to	42,867	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	74,875	equal to	74,875	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	36,743	equal to	36,743	0	O.K.	Pg20 K33..,K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,278,411	equal to	1,203,536	74,875	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,116	< or = to	4,620	-504	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	149	-149	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	74,875	equal to	74,875	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	181,600	equal to	181,600	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	5,951	equal to	5,951	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	174,476	equal to	174,476	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,857	equal to	4,857	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	42	equal to	42	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	145,258	equal to	145,258	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	397	equal to	405	-8	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	20,915	equal to	20,915	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	2,144,582	equal to	2,144,582	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	20,040	equal to	20,040	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	58,500	equal to	58,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,225,267	equal to	1,225,267	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	268,680	equal to	268,680	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	817,717	equal to	817,717	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-306,600	equal to	-306,600	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-290,166	equal to	-290,166	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	330,974	equal to	330,974	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	108,578	11,319	0	119,897	0	119,897	3,855	123,752
2. Food Purchase	0	118,852	0	118,852	0	118,852	-1,129	117,723
3. Housekeeping	82,901	16,621	0	99,522	0	99,522	67	99,589
4. Laundry	42,867	9,030	30	51,927	0	51,927	0	51,927
5. Heat and Other Utilities	0	0	52,702	52,702	0	52,702	225	52,927
6. Maintenance	24,325	6,804	26,022	57,151	0	57,151	2,105	59,256
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	258,671	162,626	78,754	500,051	0	500,051	5,123	505,174
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	800,704	52,271	4,620	857,595	0	857,595	-57	857,538
10a. Therapy	0	130	59,285	59,415	0	59,415	0	59,415
11. Activities	49,578	151	149	49,878	0	49,878	-15,775	34,103
12. Social Services	27,570	6	0	27,576	0	27,576	0	27,576
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	877,852	52,558	78,454	1,008,864	0	1,008,864	-15,832	993,032
17. Administrative	0	0	181,600	181,600	0	181,600	-106,725	74,875
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,951	5,951	0	5,951	18,959	24,910
20. Fees, Subscriptions & Promotion	0	0	4,877	4,877	0	4,877	-20	4,857
21. Clerical & General Office	36,743	4,331	11,636	52,710	0	52,710	45,158	97,868
22. Employee Benefits & Payroll	0	0	149,345	149,345	0	149,345	25,131	174,476
23. Inservice Training & Education	0	0	0	0	0	0	86	86
24. Travel and Seminar	0	0	0	0	0	0	42	42
25. Other Admin. Staff Trans	0	0	12,444	12,444	0	12,444	3,536	15,980
26. Insurance-Prop.Liab.Malpractice	0	0	17,251	17,251	0	17,251	15,095	32,346
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	36,743	4,331	383,104	424,178	0	424,178	1,262	425,440
29. Total General Administrative	1,173,266	219,515	540,312	1,933,093	0	1,933,093	-9,447	#####
30. Depreciation	0	0	28,435	28,435	0	28,435	36,058	64,493
31. Amortization of Pre-Op. & Org.	0	0	14,352	14,352	0	14,352	1,243	15,595
32. Interest	0	0	53,504	53,504	0	53,504	78,665	132,169
33. Real Estate	0	0	9,750	9,750	0	9,750	9,979	19,729
34. Rent - Facility & Grounds	0	0	112,951	112,951	0	112,951	-112,951	0
35. Rent - Equipment & Vehicles	0	0	9,929	9,929	0	9,929	809	10,738
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	228,921	228,921	0	228,921	13,803	242,724
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	20,648	0	20,648	0	20,648	0	20,648
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	145,258	145,258	0	145,258	0	145,258
43. Other (specify):*	30,270	120	216,737	247,127	0	247,127	-247,127	0
44. Total Special Cost Ce	30,270	20,768	361,995	413,033	0	413,033	-247,127	165,906
45. Grand Total	1,203,536	240,283	1,131,228	2,575,047	0	2,575,047	-242,771	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-566,757	-566,757
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	810,805	810,805
4. Supply Inventory	7,784	7,784
5. Short-Term Investments	0	0
6. Prepaid Insurance	17,740	28,881
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	18,825
9. Other (specify):	0	0
10. Total current assets	269,572	299,538
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	58,500
14. Buildings, at Historical Cost	0	1,080,286
15. Leasehold Improvements, Historical Cost	66,300	144,981
16. Equipment, at Historical Cost	2,978	268,680
17. Accumulated Depreciation (book methods)	-7,876	-817,717
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	73,342
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	239,771
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	61,402	1,047,843
25. Total Assets	330,974	1,347,381
CURRENT LIABILITIES		
26. Accounts Payable	290,949	290,949
27. Officer's Accounts Payable	500	500
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	55,753	55,753
31. Accrued Taxes Payable	31,643	31,643
32. Accrued Real Estate Taxes	0	20,040
33. Accrued Interest Payable	0	7,309
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	17,926	17,926
37. Other Current Liabilities (specify):	66,159	66,159
38. Total Current Liabilities	462,930	490,279
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,144,582
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	174,644	171,745
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	174,644	2,316,327
46.Total Liabilities	637,574	2,806,606
47.Total Equity	-306,600	-1,459,225
48.Total Liabilities and Equity	330,974	1,347,381

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,160,504
2. Discounts and Allowances for all Levels	-23,620
Subtotal - Inpatient Care	2,136,884
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	101,114
7. Oxygen	293
Subtotal - Ancillary Revenue	101,407
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,199
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	5,366
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	1,858
21. Other Medical Services	7,939
22. Laundry	0
Subtotal - Other Operating Revenue	16,362
24. Contributions	0
25. Interest and Other Investments Income	143
Subtotal - Non-Operating Revenue	143
27. Other Revenue (specify):	15,775
28. Other Revenue (specify):	-42
Subtotal - Other Revenue	15,733
30. Total Revenue	2,270,529
31. General Services	500,051
32. Health Care	1,008,864
33. General Administration	424,598
34. Ownership	228,921
35. Special Cost Centers	267,745
35. Provider Participation Fee	145,258
37. Other	0
40. Total Expenses	2,575,437
41. Income Before Income Taxes	-304,908
42. Income Taxes	0
43. Net Income or Loss for the Year	-304,908