

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Center of Macomb

Address: 400 West Grant Street 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

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

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)689-5850
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 1/1/2020 to 12/31/2020 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) Mark Petersen

(Title) Chief Executive Officer

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 Number Countryview Care Center of Macomb

0053199 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		300	1,030	1,330	8
9	SNF/PED					9
10	ICF	14,284			14,284	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,284	300	1,030	15,614	14

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

69.00%

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

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☒ NO ☐

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

YES ☐ NO ☒

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

Date started 10/1/2005

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

YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 16 and days of care provided 998

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Countryview Care Center of Macomb # 0053199 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	109,545	14,175		123,720		123,720	4,157	127,877			1
2	Food Purchase		101,788		101,788		101,788	(1,224)	100,564			2
3	Housekeeping	121,370	22,946		144,316		144,316	80	144,396			3
4	Laundry	74	11,480		11,554		11,554		11,554			4
5	Heat and Other Utilities			44,423	44,423		44,423	284	44,707			5
6	Maintenance	24,685	4,303	30,759	59,747		59,747	2,497	62,244			6
7	Other (specify):*											7
8	TOTAL General Services	255,674	154,692	75,182	485,548		485,548	5,794	491,342			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	864,562	56,495	39,892	960,949		960,949	2,113	963,062			10
10a	Therapy			134,474	134,474		134,474		134,474			10a
11	Activities	41,141	1,113		42,254		42,254	552	42,806			11
12	Social Services	30,105	6		30,111		30,111		30,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	935,808	57,614	186,366	1,179,788		1,179,788	2,665	1,182,453			16
	C. General Administration											
17	Administrative	67,500		135,000	202,500		202,500	(111,879)	90,621			17
18	Directors Fees											18
19	Professional Services			8,228	8,228		8,228	23,022	31,250			19
20	Dues, Fees, Subscriptions & Promotions			1,326	1,326		1,326	2,128	3,454			20
21	Clerical & General Office Expenses	41,671	4,485	12,143	58,299		58,299	25,659	83,958			21
22	Employee Benefits & Payroll Taxes			141,125	141,125		141,125	7,077	148,202			22
23	Inservice Training & Education							43	43			23
24	Travel and Seminar							13	13			24
25	Other Admin. Staff Transportation			6,769	6,769		6,769	2,978	9,747			25
26	Insurance-Prop.Liab.Malpractice			1,680	1,680		1,680	34,469	36,149			26
27	Other (specify):*											27
28	TOTAL General Administration	109,171	4,485	306,271	419,927		419,927	(16,490)	403,437			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,300,653	216,791	567,819	2,085,263		2,085,263	(8,031)	2,077,232			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,893	5,893		5,893	54,030	59,923			30
31	Amortization of Pre-Op. & Org.							2,486	2,486			31
32	Interest							83,876	83,876			32
33	Real Estate Taxes							22,363	22,363			33
34	Rent-Facility & Grounds			186,314	186,314		186,314	(186,314)				34
35	Rent-Equipment & Vehicles			18,869	18,869		18,869	1,510	20,379			35
36	Other (specify):*											36
37	TOTAL Ownership			211,076	211,076		211,076	(22,049)	189,027			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,473		17,473		17,473		17,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			122,412	122,412		122,412		122,412			42
43	Other (specify):*	22,270		34,492	56,762		56,762	(56,762)				43
44	TOTAL Special Cost Centers	22,270	17,473	156,904	196,647		196,647	(56,762)	139,885			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,322,923	234,264	935,799	2,492,986		2,492,986	(86,842)	2,406,144			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	(1,224)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,449)	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	1,317	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(74)	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	(9,605)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(700)	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	(30,285)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,023)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(28,819)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,819)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,842)		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

ID#0053199

Report Period Beginning:1/1/2020

Ending:12/31/2020

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Labs-Part A	\$ (6,062)	431
2	Offset Miscellaneous Office Supplies Revenue	(120)	212
3	Disallowed Special Events	176	433
4	Offset Transportation Revenue	552	114
5	Disallowed Marketing Salaries	(22,270)	435
6	Offset Miscellaneous Nursing Supplies Revenue	(1,783)	106
7	X-Rays-Part A	\$ (778)	437
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
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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	(30,285)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

☒ 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	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,157	\$ 4,157	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	80	80	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	284	284	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,497	2,497	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%	3,896	3,896	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	135,000	Petersen Health Care Management, Inc.	100.00%	23,121	(111,879)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,657	13,657	12
13	V								13
14	Total			\$ 135,000			\$ 47,692	\$ * (87,308)	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%	\$ 2,128	\$ 2,128	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,779	25,779	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,077	7,077	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	43	43	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	13	13	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,978	2,978	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	454	454	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,208	4,208	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	205	205	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	164	164	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,510	1,510	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			\$			\$ 44,559	\$ * 44,559	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 %	\$		15
16	V	2	Food		Petersen Health Properties, LLC	100.00 %			16
17	V	3	Housekeeping		Petersen Health Properties, LLC	100.00 %			17
18	V	4	Laundry		Petersen Health Properties, LLC	100.00 %			18
19	V	5	Utilities		Petersen Health Properties, LLC	100.00 %			19
20	V	6	Maintenance		Petersen Health Properties, LLC	100.00 %			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00 %			21
22	V	10	Nursing and Medical Records		Petersen Health Properties, LLC	100.00 %			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00 %			23
24	V	17	Administrative		Petersen Health Properties, LLC	100.00 %			24
25	V	19	Professional Services		Petersen Health Properties, LLC	100.00 %	3,615	3,615	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Properties, LLC	100.00 %			26
27	V	21	Clerical and General Office		Petersen Health Properties, LLC	100.00 %			27
28	V	22	Employee Benefits & Payroll		Petersen Health Properties, LLC	100.00 %			28
29	V	23	Inservice Training & Education		Petersen Health Properties, LLC	100.00 %			29
30	V	24	Travel and Seminar		Petersen Health Properties, LLC	100.00 %			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Properties, LLC	100.00 %			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Properties, LLC	100.00 %			32
33	V	30	Depreciation		Petersen Health Properties, LLC	100.00 %			33
34	V	31	Amortization		Petersen Health Properties, LLC	100.00 %			34
35	V	32	Interest		Petersen Health Properties, LLC	100.00 %	2,451	2,451	35
36	V	33	Real Estate Taxes		Petersen Health Properties, LLC	100.00 %			36
37	V	34	Rent-Facility and Grounds		Petersen Health Properties, LLC	100.00 %			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Properties, LLC	100.00 %			38
39	Total			\$			\$ 6,066	\$ * 6,066	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.

☒ 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		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	6	Maintenance	\$	Countryview Care Center Land	100.00%	\$		15
16	V	19	Professional Fees		Countryview Care Center Land	100.00%	5,750	5,750	16
17	V	21	Equipment		Countryview Care Center Land	100.00%			17
18	V	26	Insurance-Liability		Countryview Care Center Land	100.00%	9,495	9,495	18
19	V	26	Insurance-Property		Countryview Care Center Land	100.00%	11,530	11,530	19
20	V	26	Insurance-MIP		Countryview Care Center Land	100.00%	12,990	12,990	20
21	V	30	Depreciation		Countryview Care Center Land	100.00%	48,505	48,505	21
22	V	31	Amortization of Pre-Op. & Org.		Countryview Care Center Land	100.00%	2,486	2,486	22
23	V	32	Interest	671	Countryview Care Center Land	100.00%	81,894	81,223	23
24	V	33	Real Estate Taxes		Countryview Care Center Land	100.00%	22,199	22,199	24
25	V	34	Rent-Facility and Grounds	186,314	Countryview Care Center Land	100.00%		(186,314)	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			\$ 186,985			\$ 194,849	\$ * 7,864	39

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

Facility Name & ID Number Countryview Care Center of Macomb# 0053199

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 Center of Macomb# 0053199

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Center of Macomb# 0053199

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Betty's Garden	Kewanee				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 Center of Macomb # 0053199 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Petersen Health Care Management, Inc.
Street Address 830 W. Trailcreek Drive
City / State / Zip Code Peoria, IL 61614
Phone Number (309) 691-8113
Fax Number (309) 691-8622

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	15,614	\$ 4,157	1
2	2	Food	Resident Days	1,282,791	75	0	0	15,614	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	15,614	80	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	15,614	284	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	15,614	2,497	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,614	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	15,614	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	15,614	3,896	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	15,614	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	15,614	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	15,614	23,121	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	15,614	13,657	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	15,614	2,128	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	15,614	25,779	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,282,791	75	581,393	0	15,614	7,077	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	15,614	43	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	15,614	13	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	15,614	2,978	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	15,614	454	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	15,614	4,208	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	15,614	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	15,614	205	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	15,614	164	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	15,614	1,510	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 92,251	25

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	45,811	3	\$		15,614	\$	1
2	2	Food	Resident Days	45,811	3			15,614		2
3	3	Housekeeping	Resident Days	45,811	3			15,614		3
4	5	Utilities	Resident Days	45,811	3			15,614		4
5	6	Maintenance	Resident Days	45,811	3			15,614		5
6	7	Mgmt. Allocation of Benefits	Resident Days	45,811	3			15,614		6
7	9	Medical Director	Resident Days	45,811	3			15,614		7
8	10	Nursing and Medical Records	Resident Days	45,811	3			15,614		8
9	10A	Therapy	Resident Days	45,811	3			15,614		9
10	15	Mgmt. Allocation of Benefits	Resident Days	45,811	3			15,614		10
11	17	Administrative	Resident Days	45,811	3			15,614		11
12	19	Professional Services	Resident Days	45,811	3			15,614		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	45,811	3	10,605		15,614	3,615	13
14	21	Clerical and General Office	Resident Days	45,811	3			15,614		14
15	22	Employee Benefits and Payroll Tax	Resident Days	45,811	3			15,614		15
16	23	Inservice Training & Education	Resident Days	45,811	3			15,614		16
17	24	Travel and Seminar	Resident Days	45,811	3			15,614		17
18	25	Other Admin. Staff Transport.	Resident Days	45,811	3			15,614		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	45,811	3			15,614		19
20	30	Depreciation	Resident Days	45,811	3			15,614		20
21	31	Amortization	Resident Days	45,811	3			15,614		21
22	32	Interest	Resident Days	45,811	3	7,191		15,614	2,451	22
23	33	Real Estate Taxes	Resident Days	45,811	3			15,614		23
24	35	Rent-Equipment & Vehicles	Resident Days	45,811	3			15,614		24
25	TOTALS					\$ 17,796	\$		\$ 6,066	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	\$ 1,982,430	12/31/2044	Varies	\$ 81,894	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,160,000	\$ 1,982,430			\$ 81,894	9
	B. Non-Facility Related*											
10								Interest Income Offset			(674)	10
11								Home Office Allocation-PHCM			205	11
12								Home Office Allocation-PHP			2,451	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 1,982	14
15	TOTALS (line 9+line14)						\$ 2,160,000	\$ 1,982,430			\$ 83,876	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,990 Line # 26

* 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Care Center of Macomb 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-400-806-00	Long-Term Care Facility	\$ 21,316.02	\$ 21,316.02
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 21,316.02	\$ 21,316.02

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 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: 30
3. Current Period Amortization: 2,486

4. Dates Incurred: 2015

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 Facility	103,237	2005	\$ 58,500	1
	2				2
	3 TOTALS	103,237		\$ 58,500	3

Facility Name & ID Number Countryview Care Center of Macomb

0053199

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		2005	1970	\$ 1,072,000	\$	25	\$ 43,280	\$ 43,280	\$ 670,840	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement			2006	15,000		15	1,000	1,000	14,500	9
10	Sprinkler System			2007	5,623		15			5,623	10
11	Countertop Installation			2009	4,183		15	278	278	3,197	11
12	A/C Unit			2009	6,031		7			6,031	12
13	Dry System Repair			2009	11,587		7			11,587	13
14	Sprinkler System Replacement			2009	13,900		15	926	926	10,649	14
15	Dry Pipe Valve Repair			2009	4,996		7			4,996	15
16	Dry System Replacement			2012	3,349		7			3,349	16
17	Cafeteria Door			2013	3,658		7	265	265	3,658	17
18	Landscaping Lighting			2013	9,592		15	640	640	4,800	18
19	Roof Replacement			2014	63,350		25	2,534	2,534	16,471	19
20	Roofing Repair			2016	2,950		7	422	422	1,899	20
21	Boiler Repair			2017	2,521		7	360	360	1,260	21
22	Parking Lot Resurfacing			2017	36,774		15	2,452	2,452	8,582	22
23	Sprinkler Repair			2018	3,626		7	518	518	1,295	23
24	Restoration of Fire Damage to Common Area, Cafeteria			2020	5,000		15	167	167	167	24
25											25
26											26
27											27
28	Building Booked					42,310			(42,310)		28
29	Building Improvement Booked					9,776			(9,776)		29
30											30
31	2020-Home Office Allocation-Building Improvements				7,895			189	189		31
32	2020-Home Office Allocation-Land Improvements				792			50	50		32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,272,827	\$52,086		\$53,081	\$995	\$768,904	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	\$21,863	\$2,312	\$2,873	\$561	5-10 yrs.	\$7,701	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	232,943					232,943	73
74	Home Office Allocation			3,969	3,969			74
75	TOTALS	\$254,806	\$2,312	\$6,842	\$4,530		\$240,644	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$1,586,13381
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,39882
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$59,92383
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,52584
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,009,54885

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 20,379 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	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. /2021	\$
13. /2022	\$
14. /2023	\$

* 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 Center of Macomb
0053199

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	11,524
Dishwasher		701
Copier		6,644
Home Office Allocation		1,510
		<u>20,379</u>

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

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

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,311	\$ 64,665	\$	4,311	\$ 64,665	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,082	16,230		1,082	16,230	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,572	53,579		3,572	53,579	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 prescripts				17,473		17,473	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,965	\$ 134,474	\$ 17,473	8,965	\$ 151,947	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	\$ 851,441	\$ 851,441	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,093)	570,907	570,907	3
4	Supply Inventory (priced at Cost)	7,784	7,784	4
5	Short-Term Investments			5
6	Prepaid Insurance	10,647	24,047	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		17,683	8
9	Other(specify): Employee Education Loans	753	753	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,441,532	\$ 1,472,615	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		1,079,895	14
15	Leasehold Improvements, at Historical Cost	74,926	192,932	15
16	Equipment, at Historical Cost	16,302	254,806	16
17	Accumulated Depreciation (book methods)	(27,368)	(1,009,548)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		63,397	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		275,405	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans		7,418	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,860	\$ 922,805	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,505,392	\$ 2,395,420	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 530,493	\$ 530,493	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,882	62,882	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		21,960	32
33	Accrued Interest Payable		6,757	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	73,292	73,292	36
37	Accrued Management Fees	17,683	17,683	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 684,350	\$ 713,067	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,982,430	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	400,000	400,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 400,000	\$ 2,382,430	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,084,350	\$ 3,095,497	46
47	TOTAL EQUITY(page 18, line 24)	\$ 421,042	\$ (700,077)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,505,392	\$ 2,395,420	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (199,178)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(181,670)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (380,848)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	801,890	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)	\$ 801,890	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)	\$ 421,042	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Countryview Care Center of Macomb

0053199

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 2,767,191	1
2	Discounts and Allowances for all Levels	(282,708)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,484,483	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,814	6
7	Oxygen	2,066	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 178,880	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	1,224	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	26,581	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,363	20
21	Other Medical Services	7,352	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,520	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	(552)	28
28a	Miscellaneous and Illinois Cares Revenue	594,542	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 593,990	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,294,876	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	485,548	31
32	Health Care	1,179,788	32
33	General Administration	419,927	33
	B. Capital Expense		
34	Ownership	211,076	34
	C. Ancillary Expense		
35	Special Cost Centers	74,235	35
36	Provider Participation Fee	122,412	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,492,986	40
41	Income before Income Taxes (line 30 minus line 40)**	801,890	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 801,890	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,015,154	44
45	Private Pay - Net Inpatient Revenue	38,440	45
46	Medicare - Net Inpatient Revenue	418,181	46
47	Other-(specify) Insurance Net Inpatient Revenue	12,708	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,484,483	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.

Facility Name & ID Number Countryview Care Center of Macomb# 0053199

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	1,898	1,906	\$ 64,652	\$ 33.92	1
2	Assistant Director of Nursing	1,000	1,024	27,958	27.30	2
3	Registered Nurses	1,950	1,971	53,748	27.27	3
4	Licensed Practical Nurses	8,818	8,931	242,860	27.19	4
5	CNAs & Orderlies	33,019	33,951	408,600	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	601	601	9,006	14.99	9
10	Activity Assistants	1,277	1,277	17,785	13.93	10
11	Social Service Workers	2,020	2,070	30,105	14.54	11
12	Dietician					12
13	Food Service Supervisor	1,506	1,615	27,919	17.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,883	8,993	81,626	9.08	15
16	Dishwashers					16
17	Maintenance Workers	1,492	1,525	24,685	16.19	17
18	Housekeepers	10,565	11,034	121,370	11.00	18
19	Laundry	8	8	74	9.25	19
20	Administrator	1,845	1,925	67,500	35.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,851	1,955	41,671	21.32	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	935	935	21,330	22.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	3,746	3,853	82,034	21.29	33
34	TOTAL (lines 1 - 33)	81,414	83,574	\$ 1,322,923 *	\$ 15.83	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,705	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	30	1,510	L10, C3	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)	30	\$ 18,215		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	901	\$ 33,677	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	901	\$ 33,677		53

Countryview Care Center of Macomb
0053199
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period Total Salaries, Wages	Average Hourly Wage
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued		
Care Plan Coordinator	1,440	1,517	45,414	29.94
Transportation	1,194	1,220	14,350	11.76
Marketing	1,112	1,116	22,270	19.96
TOTAL	3,746	3,853	82,034	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Ashley Jones	Administrator	0	\$ 15,361
Rosemary Trinkle	Administrator	0	52,139
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,500
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 135,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 135,000
C. Professional Services			
Vendor/Payee	Type		Amount
Ability Network	Computer Services		\$ 6,928
Comcast	Computer Services		1,300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,228
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 15,013
Unemployment Compensation Insurance			12,648
FICA Taxes			94,594
Employee Health Insurance			3,596
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			1,174
Home Office Allocation			7,077
Administrator Benefits			14,100
TOTAL (agree to Schedule V, line 22, col.8)			\$ 148,202
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			299
Health Care Worker Background Check (Indicate # of checks performed 53)			
Patient Background Checks	3		79
Miscellaneous Licenses & Permits			948
Home Office Allocation			2,128
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 3,454
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			13
Entertainment Expense	(		)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 13

*** Attach copy of IMRF notifications**

****See instructions.**

Countryview Care Center of Macomb
0053199
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,228
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	240
Duane Morris	Legal	336
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	13
Miller, Hall, Triggs	Legal	42
Miscellaneous	Legal	15
SB2	Legal	124
SmithAmundsen LLC	Legal	768
Sorling Northrup	Legal	219
Illinois Secretary of State	Legal	403
CliftonLarsonAllen	Accounting	9,916
Ginoli & Co.	Accounting	681
Ability Network	Computer Services	2,451
Allscripts	Computer Services	387
AOD Matrix Care	Computer Services	4,304
AT&T	Computer Services	5
ATS	Computer Services	235
CCH	Computer Services	14
Charter Communications	Computer Services	22
Citrix Systems	Computer Services	73
Comcast	Computer Services	25
ITSavvy	Computer Services	113
Kemper Technology	Computer Services	559
Miscellaneous	Computer Services	160
Pearl Technology	Computer Services	101
Stratus Networks	Computer Services	444
TR Professional	Computer Services	10
David Budde	Other Prof Fees	10
DJ Howard and Associates	Other Prof Fees	19
Getzler Henrich & Associates	Other Prof Fees	76
LRI Consulting Services	Other Prof Fees	74
McQuellon Consulting	Other Prof Fees	47
Miscellaneous	Other Prof Fees	36
Optimizer	Other Prof Fees	40
Registered Agent Solutions	Other Prof Fees	22
RSM McGladrey	Other Prof Fees	243
SB2	Other Prof Fees	311
Sedgwick CMS	Other Prof Fees	419
Tarver Program Consultants	Other Prof Fees	58
Total (agree to Schedule V, line 19, column 8)		31,250

Countryview Care of Macomb

Other Administrative Staff Transportation Schedule

1/1-12/31 2020

Employee Name & Title	Date	Type of Expense	Expense
Transportation Dept.	Jan-20	Gas for Van	319.60
Tiffany Dowell-Community Relations Coordinator	Jan-20	Mileage Reimbursement	401.40
Transportation Dept.	Feb-20	Gas for Van	481.74
Tiffany Dowell-Community Relations Coordinator	Feb-20	Mileage Reimbursement	408.00
Transportation Dept.	Mar-20	Gas for Van	293.14
Transportation Dept.	Mar-20	Oil Change	44.52
Tiffany Dowell-Community Relations Coordinator	Mar-20	Mileage Reimbursement	308.40
Transportation Dept.	Apr-20	Gas for Van	25.00
Transportation Dept.	May-20	Gas for Van	30.00
Kendel Brooks-Regional Director	May-20	Mileage Reimbursement	55.20
Transportation Dept.	Jun-20	Gas for Van	40.00
Transportation Dept.	Jul-20	Oil Change, Air Conditoner Repair	262.15
Transportation Dept.	Aug-20	Gas for Van	494.29
Transportation Dept.	Sep-20	Gas for Van	420.72
Transportation Dept.	Oct-20	Gas for Van	237.97
Transportation Dept.	Oct-20	Torque and Solenoid Repairs	1,503.64
Jocelyn Little-RN	Oct-20	Mileage Reimbursement	51.60
Katherine Wright-RN	Oct-20	Mileage Reimbursement	126.00
Trisha Bauman-RN	Oct-20	Mileage Reimbursement	37.20
Transportation Dept.	Nov-20	Gas for Van	602.29
Transportation Dept.	Dec-20	Gas for Van	626.60
Total			6,769.46

Countryview Care Center of Macomb
0053199

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	3,571
Auto Repairs		1,810
Mileage-Travel		1,388
Home Office Allocation		<u>2,978</u>
		<u>9,747</u>

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?
If YES, give association name and amount.

No
- (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?

No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 8,622 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9) Are you presently operating under a sublease agreement?

YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
- (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.

\$ 122,412
- (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.

No

- (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?
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.

No
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 1,224
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

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.

Yes \$ N/A

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

No