FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0047431

Facility Name: Countryview Care Ctr Macomb

Address: 400 West Grant St (Number) Macomb (City) 61455 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 1/1/2013 to 12/31/2013 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 Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			898	898	8
9	SNF/PED					9
10	ICF	15,032	2,774		17,806	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,032	2,774	898	18,704	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.65%

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?
YES [ ] NO [X]

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 [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 898

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	108,803	11,171	1,031	121,005		121,005	3,686	124,691			1
2	Food Purchase		120,599		120,599		120,599	(4,851)	115,748			2
3	Housekeeping	71,169	17,594		88,763		88,763	37	88,800			3
4	Laundry	50,958	11,136	70	62,164		62,164		62,164			4
5	Heat and Other Utilities			49,802	49,802		49,802	280	50,082			5
6	Maintenance	30,096	7,366	14,263	51,725		51,725	1,805	53,530			6
7	Other (specify):* Home Off. Ben. All.							208	208			7
8	**TOTAL General Services**	261,026	167,866	65,166	494,058		494,058	1,165	495,223			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	745,035	55,115	4,111	804,261		804,261	13	804,274			10
10a	Therapy			118,371	118,371		118,371		118,371			10a
11	Activities	31,205	661	2,380	34,246		34,246	(7,216)	27,030			11
12	Social Services	26,433			26,433		26,433		26,433			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	802,673	55,776	138,862	997,311		997,311	(7,203)	990,108			16
	C. General Administration											
17	Administrative			216,000	216,000		216,000	(164,440)	51,560			17
18	Directors Fees											18
19	Professional Services			8,059	8,059		8,059	97,808	105,867			19
20	Dues, Fees, Subscriptions & Promotions			5,766	5,766		5,766	746	6,512			20
21	Clerical & General Office Expenses	26,476	3,899	8,292	38,667		38,667	67,023	105,690			21
22	Employee Benefits & Payroll Taxes			176,175	176,175		176,175	(21)	176,154			22
23	Inservice Training & Education							74	74			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			18,294	18,294		18,294	3,412	21,706			25
26	Insurance-Prop.Liab.Malpractice			23,166	23,166		23,166	659	23,825			26
27	Other (specify):* Home Off. Ben. All.							4,228	4,228			27
28	**TOTAL General Administration**	26,476	3,899	455,752	486,127		486,127	9,493	495,620			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,090,175	227,541	659,780	1,977,496		1,977,496	3,455	1,980,951			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Countryview Care Ctr Macomb #0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,185	26,185		26,185	29,460	55,645			30
31	Amortization of Pre-Op. & Org.							36,384	36,384			31
32	Interest			6,358	6,358		6,358	106,996	113,354			32
33	Real Estate Taxes			19,768	19,768		19,768	296	20,064			33
34	Rent-Facility & Grounds			100,486	100,486		100,486	(100,486)				34
35	Rent-Equipment & Vehicles			13,495	13,495		13,495	546	14,041			35
36	Other (specify):*											36
37	**TOTAL Ownership**			166,292	166,292		166,292	73,196	239,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,890		48,890		48,890		48,890			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,657	141,657		141,657		141,657			42
43	Other (specify):* Non-allowable Costs	31,625	777	68,386	100,788		100,788	(100,788)				43
44	**TOTAL Special Cost Centers**	31,625	49,667	210,043	291,335		291,335	(100,788)	190,547			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,121,800	277,208	1,036,115	2,435,123		2,435,123	(24,137)	2,410,986			45

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,930)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,135)	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	(1,279)	30		9
10	Interest and Other Investment Income	(6,780)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(231)	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	(17,351)	43		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,000)	43		24
25	Fund Raising, Advertising and Promotional	(33,859)	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	(13,011)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,676)		$	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)	97,539	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 97,539		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,137)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Countryview Care Ctr Macomb

ID# 0047431

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,152)	43	1
2	X-Rays-Part A	(986)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(158)	21	3
4	Disallow Chamber of Commerce Dues	(525)	20	4
5	Disallowed Special Events	(15)	43	5
6	Offset Transportation Revenue	(7,216)	11	6
7	Disallowed Travel Air	(959)	43	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**	(13,011)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Care Ctr Macomb **#** 0047431 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	3,686	0	0	0	0	0	0	0	0	0	3,686	1
2	Food Purchase	(4,930)	79	0	0	0	0	0	0	0	0	0	(4,851)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	280	0	0	0	0	0	0	0	0	0	280	5
6	Maintenance	0	1,805	0	0	0	0	0	0	0	0	0	1,805	6
7	Other (specify):*	0	208	0	0	0	0	0	0	0	0	0	208	7
8	**TOTAL General Services**	(4,930)	6,095	0	0	0	0	0	0	0	0	0	1,165	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13	0	0	0	0	0	0	0	0	0	13	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,216)	0	0	0	0	0	0	0	0	0	0	(7,216)	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**	(7,216)	13	0	0	0	0	0	0	0	0	0	(7,203)	16
	C. General Administration													
17	Administrative	0	(164,440)	0	0	0	0	0	0	0	0	0	(164,440)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,770	0	90,038	0	0	0	0	0	0	0	97,808	19
20	Fees, Subscriptions & Promotions	(525)	0	494	777	0	0	0	0	0	0	0	746	20
21	Clerical & General Office Expenses	(158)	0	45,677	3,503	18,001	0	0	0	0	0	0	67,023	21
22	Employee Benefits & Payroll Taxes	0	0	0	(21)	0	0	0	0	0	0	0	(21)	22
23	Inservice Training & Education	0	0	74	0	0	0	0	0	0	0	0	74	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,412	0	0	0	0	0	0	0	0	3,412	25
26	Insurance-Prop.Liab.Malpractice	0	0	659	0	0	0	0	0	0	0	0	659	26
27	Other (specify):*	0	0	4,228	0	0	0	0	0	0	0	0	4,228	27
28	**TOTAL General Administration**	(683)	(156,670)	54,548	94,297	18,001	0	0	0	0	0	0	9,493	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,829)	(150,562)	54,548	94,297	18,001	0	0	0	0	0	0	3,455	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,279)	0	3,028	206	27,505	0	0	0	0	0	0	29,460	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	36,384	0	0	0	0	0	0	36,384	31
32	Interest	(6,780)	0	5,037	32,525	76,214	0	0	0	0	0	0	106,996	32
33	Real Estate Taxes	0	0	296	0	0	0	0	0	0	0	0	296	33
34	Rent-Facility & Grounds	0	0	0	0	(100,486)	0	0	0	0	0	0	(100,486)	34
35	Rent-Equipment & Vehicles	0	0	546	0	0	0	0	0	0	0	0	546	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,059)	0	8,907	32,731	39,617	0	0	0	0	0	0	73,196	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):*	(100,788)	0	0	0	0	0	0	0	0	0	0	(100,788)	43
44	TOTAL Special Cost Centers	(100,788)	0	0	0	0	0	0	0	0	0	0	(100,788)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(121,676)	(150,562)	63,455	127,028	57,618	0	0	0	0	0	0	(24,137)	45

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

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

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

1 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, Inc.	100.00%	$ 3,686	$ 3,686	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	79	79	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	280	280	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,805	1,805	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	208	208	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13	13	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	216,000	Petersen Health Care, Inc.	100.00%	51,560	(164,440)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	7,770	7,770	12
13	V								13
14	Total			$ 216,000			$ 65,438	$ * (150,562)	14

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 494	$ 494	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	45,677	45,677	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	74	74	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	4	4	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,412	3,412	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	659	659	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,228	4,228	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,028	3,028	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,037	5,037	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	296	296	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	546	546	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			$			$ 63,455	$ * 63,455	39

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 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)	
15	V	1	Dietary	$		100.00%	$ 0	$	15
16	V	2	Food			100.00%	0		16
17	V	3	Housekeeping			100.00%	0		17
18	V	4	Laundry			100.00%	0		18
19	V	5	Utilities			100.00%	0		19
20	V	6	Maintenance			100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits			100.00%	0		21
22	V	10	Nursing and Medical Records			100.00%	0		22
23	V	12	Social Services			100.00%	0		23
24	V	17	Administrative			100.00%	0		24
25	V	19	Professional Services			100.00%	90,038	90,038	25
26	V	20	Dues, Fees, Subs & Promotions			100.00%	777	777	26
27	V	21	Clerical and General Office			100.00%	3,503	3,503	27
28	V	22	Employee Benefits & Payroll			100.00%	(21)	(21)	28
29	V	23	Inservice Training & Education			100.00%	0		29
30	V	24	Travel and Seminar			100.00%	0		30
31	V	25	Other Admin. Staff Transport.			100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.			100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits			100.00%	0		33
34	V	30	Depreciation			100.00%	206	206	34
35	V	32	Interest			100.00%	32,525	32,525	35
36	V	33	Real Estate Taxes			100.00%	0		36
37	V	34	Rent-Facility and Grounds			100.00%	0		37
38	V	35	Rent-Equipment & Vehicles			100.00%	0		38
39	Total			$			$ 127,028	$ * 127,028	39

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 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)	
15	V	30	Depreciation	$	Petersen Countryview of Macomb, LLC	100.00%	$ 27,505	$ 27,505	15
16	V	31	Amortization		Petersen Countryview of Macomb, LLC	100.00%	36,384	36,384	16
17	V	32	Interest		Petersen Countryview of Macomb, LLC	100.00%	76,214	76,214	17
18	V	21	Clerical and General Office		Petersen Countryview of Macomb, LLC	100.00%	18,001	18,001	18
19	V	34	Rent-Facility and Grounds	100,486	Petersen Countryview of Macomb, LLC	100.00%		(100,486)	19
20	V								20
21	V								21
22	V								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			$ 100,486			$ 158,104	$ * 57,618	39

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				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 # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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 # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

Name of Related Organization: Petersen Health Care, 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 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	1,560,986	75	$ 307,592	$ 295,212	18,704	$ 3,686	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	18,704	79	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	18,704	37	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	18,704	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	18,704	280	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	18,704	1,805	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	18,704	208	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	18,704	13	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	18,704	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	18,704	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	18,704	51,560	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	18,704	7,770	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	18,704	494	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	18,704	45,677	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	18,704	74	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	18,704	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	18,704	3,412	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	18,704	659	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	18,704	4,228	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	18,704	3,028	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	18,704	5,037	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	18,704	296	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	18,704	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	18,704	546	24
25	TOTALS					$ 11,032,372	$ 8,354,323		$ 128,893	25

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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 [X] NO [ ]

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

Name of Related Organization: Petersen Health Operations, 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	408,598	21	$	$	18,704	$	1
2	2	Food	Resident Days	408,598	21			18,704		2
3	3	Housekeeping	Resident Days	408,598	21			18,704		3
4	4	Laundry	Resident Days	408,598	21			18,704		4
5	5	Utilities	Resident Days	408,598	21			18,704		5
6	6	Maintenance	Resident Days	408,598	21			18,704		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21			18,704		7
8	10	Nursing and Medical Records	Resident Days	408,598	21			18,704		8
9	12	Social Services	Resident Days	408,598	21			18,704		9
10	17	Administrative	Resident Days	408,598	21			18,704		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927		18,704	90,038	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972		18,704	777	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520		18,704	3,503	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)		18,704	(21)	14
15	23	Inservice Training & Education	Resident Days	408,598	21			18,704		15
16	24	Travel and Seminar	Resident Days	408,598	21			18,704		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21			18,704		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21			18,704		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21			18,704		19
20	30	Depreciation	Resident Days	408,598	21	4,500		18,704	206	20
21	32	Interest	Resident Days	408,598	21	710,525		18,704	32,525	21
22	33	Real Estate Taxes	Resident Days	408,598	21			18,704		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21			18,704		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21			18,704		24
25	TOTALS					$ 2,774,979	$		$ 127,028	25

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/19/2007	$ 425,000	$ Refinanced	12/31/2013	Varies	$ 6,358	1
2	Lancaster Pollard		X	Bridge Loan	Varies	7/1/13	1,988,194	1,988,194	6/30/14	Varies	76,214	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,413,194	$ 1,988,194			$ 82,572	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(6,780)	11
12								Home Office Allocation-PHC			5,037	12
13								Home Office Allocation-PHO			32,525	13
14	TOTAL Non-Facility Related						$	$			$ 30,782	14
15	TOTALS (line 9+line14)						$ 2,413,194	$ 1,988,194			$ 113,354	15

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

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

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 19,068	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012	$ 19,132	2
3. Under or (over) accrual (line 2 minus line 1).		$ 64	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,704	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation**		296	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 20,064	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	39,291	8
	2009	26,951	9
	2010	18,407	10
	2011	18,507	11
	2012	19,132	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Care Ctr Macomb COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0047431

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-400-806-00	Long-Term Care Facility	$ 19,132.00	$ 19,132.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,132.00	$ 19,132.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 36,384 2. Number of Years Over Which it is Being Amortized: 1

3. Current Period Amortization: 36,384 4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 1,057,000	$	25	$ 42,280	$ 42,280	$ 359,380	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement			2006	15,000		15	1,000	1,000	8,500	9
10	Windows			2007	524		15	35	35	227	10
11	Sprinkler System			2007	11,246		15	750	750	4,875	11
12	Countertop Installation			2009	4,183		15	278	278	1,251	12
13	A/C Unit			2009	6,031		7	862	862	3,879	13
14	Dry System Repair			2009	11,587		7	1,656	1,656	7,452	14
15	Sprinkler System Replacement			2009	13,900		15	926	926	4,167	15
16	Dry Pipe Valve Repair			2009	4,996		7	714	714	3,570	16
17	Dry System Replacement			2012	3,349		7	478	478	717	17
18	Cafeteria Door			2013	3,658		7	261	261	261	18
19	Landscaping Lighting			2013	9,592		15	320	320	320	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,000			(1,000)		30
31	Building Booked					42,310			(42,310)		31
32	Building Improvement Booked					6,053			(6,053)		32
33											33
34	2013-Home Office Allocation-Building Improvements				8,795			211	211		34
35	2013-Home Office Allocation-Land Improvements				821			52	52		35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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)		$ 1,150,682	$ 49,363		$ 49,823	$ 460	$ 394,599	70

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 25,725	$ 3,678	$ 2,573	$ (1,105)	5-10 yrs.	$ 14,938	71
72	Current Year Purchases	5,561	649	278	(371)	10 yrs.	278	72
73	Fully Depreciated Assets	207,218					207,218	73
74	Home Office Allocation			2,971	2,971			74
75	TOTALS	$ 238,504	$ 4,327	$ 5,822	$ 1,495		$ 222,434	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	76
77										77
78										78
79										79
80	TOTALS			$ 27,198	$	$	$		$ 27,198	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,474,884	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,690	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,645	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,955	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 644,231	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 14,041 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

* 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
0047431
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	6,184
Dishwasher		986
Laundry Equipment		-
Copier		6,325
Home Office Allocation		546
		14,041

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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
   - [X] 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.

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	3,533	$ 52,999	$	3,533	$ 52,999	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		489	7,338		489	7,338	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,869	58,034		3,869	58,034	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				48,890		48,890	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			$	7,891	$ 118,371	$ 48,890	7,891	$ 167,261	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.

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 675	$ 675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 49,958)	646,477	661,449	3
4	Supply Inventory (priced at)	7,784	7,784	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,905	21,905	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners Due to Due From	791,923	791,923	8
9	Other(specify): Prepaid Other		47,004	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,468,764	$ 1,530,740	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		1,065,795	14
15	Leasehold Improvements, at Historical Cost		84,887	15
16	Equipment, at Historical Cost		265,702	16
17	Accumulated Depreciation (book methods)		(644,231)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		36,384	20
21	Restricted Funds	17,968	85,413	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): A/R Other	14,972	14,972	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 32,940	$ 967,422	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,501,704	$ 2,498,162	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,456,346	$ 1,456,346	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,256	14,256	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,261	4,261	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,704	19,704	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	39,044	39,044	36
37	Accrued Management Fees	152,178	152,178	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,685,789	$ 1,685,789	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,988,194	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interco Loans Payable		24,907	43
44	Accrued Rent	14,973	14,973	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 14,973	$ 2,028,074	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,700,762	$ 3,713,863	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (199,058)	$ (1,215,701)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,501,704	$ 2,498,162	48

*(See instructions.)

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,281,746)	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(1,657)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,283,403)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	113,881	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)**	$ 113,881	17	
	B. Transfers (Itemize):			
18	**Transfer of Net Assets**	970,464	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 970,464	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (199,058)	24	*

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

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,400,829	1
2	Discounts and Allowances for all Levels	(145,819)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,255,010	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,205	6
7	Oxygen	85	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,290	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	4,930	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,957	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,533	20
21	Other Medical Services	1,130	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 100,550	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,780	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,780	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	158	28
28a	Transportation Revenue	7,216	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,374	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,549,004	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	494,058	31
32	Health Care	997,311	32
33	General Administration	486,127	33
	B. Capital Expense		
34	Ownership	166,292	34
	C. Ancillary Expense		
35	Special Cost Centers	149,678	35
36	Provider Participation Fee	141,657	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,435,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	113,881	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 113,881	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,780,469	44
45	Private Pay - Net Inpatient Revenue	350,960	45
46	Medicare - Net Inpatient Revenue	125,507	46
47	Other-(specify) Charity and Insurance Contractual Allowance	(1,926)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,255,010	49

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

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

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,907	1,907	$ 56,420	$ 29.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,703	5,029	134,367	26.72	3
4	Licensed Practical Nurses	8,482	8,849	197,297	22.30	4
5	CNAs & Orderlies	27,334	28,013	313,951	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	1,944	20,131	10.36	9
10	Activity Assistants	5	5	41	8.20	10
11	Social Service Workers	1,821	2,017	26,433	13.11	11
12	Dietician					12
13	Food Service Supervisor	1,949	1,949	26,057	13.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,031	6,220	82,746	13.30	15
16	Dishwashers					16
17	Maintenance Workers	2,055	2,108	30,096	14.28	17
18	Housekeepers	7,305	7,852	71,169	9.06	18
19	Laundry	4,573	4,801	50,958	10.61	19
20	Administrator	2,080	2,080	51,560	24.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,524	1,545	26,476	17.14	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	5,095	5,095	85,658	16.81	33
34	TOTAL (lines 1 - 33)	76,763	79,414	$ 1,173,360 *	$ 14.78	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	21	$ 1,031	L1, C3	35
36	Medical Director	Monthly	14,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,782	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)	21	$ 18,813		49

C. CONTRACT NURSES

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

Countryview Care Ctr Macomb
0047431
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,993	1,993	43,000	21.58
Transportation		1,109	1,109	11,033	9.95
Marketing		1,993	1,993	31,625	15.87
	TOTAL	5,095	5,095	85,658	

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Kehr	Administrator	0	$ 23,852
LeAnn Fecht	Administrator	0	27,708
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,560

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 216,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 216,000

C. Professional Services

Vendor/Payee	Type	Amount
Logonix Corporation	Computer Services	580
E-Health Data Solutions	Computer Services	6,763
Honkamp Krueger & Co.	Accounting Fees	102
Gail and Rice	Accounting Fees	614
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,059

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,334
Unemployment Compensation Insurance	35,829
FICA Taxes	84,547
Employee Health Insurance	19,220
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,024
Employee Retirement	221
Home Office Allocation	(21)
TOTAL (agree to Schedule V, line 22, col.8)	$ 176,154

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 76	761
Miscellaneous Licenses & Permits	500
Miscellaneous Dues & Subscriptions	525
Home Office Allocation	1,271
Less: Public Relations Expense	(525)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,512

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4

**See instructions.

Countryview Care Ctr Macomb
0047431
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,059
Home Office Allocation		
SmithAmundsen	Legal	462
Cole, Schotz, Meisel	Legal	254
Black, Hedin, Ballard	Legal	23
Elias, Meginnes, Riffle & Seghetti	Legal	46
Miller, Hall, and Triggs	Legal	972
Evapar	Legal	187
Ginoli & Company	Accountants	2674
E-Health Data Solutions	Computer Services	3326
Miscellaneous	Computer Services	72
Odessian LLC	Computer Services	36
CCH	Computer Services	11
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	10
Macquarie Technology Services	Computer Services	66
Advanced Answers on Demand	Computer Services	3420
TeamViewer	Computer Services	11
Stratus Networks	Computer Services	276
Kemper Technology	Computer Services	213
AT&T	Computer Services	4
Medifax	Computer Services	31
Vision Share/Ability Network	Computer Services	468
Barracuda	Computer Services	84
CIAN	Computer Services	112
Comcast	Computer Services	25
Emdeon	Computer Services	38

Marotta Gund Budd & Dzera	Other Prof Fees	83490
David Budde	Other Prof Fees	22
Pharmacy Price Mangement	Other Prof Fees	430
All Scripts	Other Prof Fees	767
Registered Agent Solutions	Other Prof Fees	36
Healthink	Other Prof Fees	238
Total (agree to Schedule V, line 19, column 8)		105,867

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Countryview Care Ctr Macomb # 0047431 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,918** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **141,657**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,930**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **7,216**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Countryview Care Ctr M** **02:09 PM** **5/20/2014**

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	-24,137	equal to	-24,137	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	113,354	equal to	113,354	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	20,064	equal to	20,064	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	36,384	equal to	36,384	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	55,645	equal to	55,645	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	14,041	equal to	14,041	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	118,371	equal to	118,371	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	48,890	equal to	48,890	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	494,058	equal to	494,058	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	997,311	equal to	997,311	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	486,127	equal to	486,127	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	166,292	equal to	166,292	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	149,678	equal to	149,678	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	141,657	equal to	141,657	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	745,035	equal to	745,035	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	31,205	equal to	31,205	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	26,433	equal to	26,433	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	108,803	equal to	108,803	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	30,096	equal to	30,096	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	71,169	equal to	71,169	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	50,958	equal to	50,958	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	51,560	equal to		51,560	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	26,476	equal to	26,476	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	1,173,360	equal to	1,121,800	51,560	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,031	< or = to	1,031	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,000	< or = to	14,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,782	< or = to	4,111	-329	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	2,380	-2,380	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.	51,560	equal to		51,560	FAILED	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	216,000	equal to	216,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	8,059	equal to	8,059	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	176,154	equal to	176,154	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,512	equal to	6,512	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4	equal to	4	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	141,657	equal to	141,657	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	-21	21	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
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	898	equal to	898	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	97,539	equal to	97,539	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,988,194	equal to	1,988,194	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	19,704	equal to	19,704	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	1,150,682	equal to	1,150,682	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	265,702	equal to	265,702	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	644,231	equal to	644,231	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-199,058	equal to	-199,058	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	113,881	equal to	113,881	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..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,501,704	equal to	1,501,704	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	108,803	11,171	1,031	121,005	0	121,005	3,686	124,691
2. Food Purchase	0	120,599	0	120,599	0	120,599	-4,851	115,748
3. Housekeeping	71,169	17,594	0	88,763	0	88,763	37	88,800
4. Laundry	50,958	11,136	70	62,164	0	62,164	0	62,164
5. Heat and Other Utilities	0	0	49,802	49,802	0	49,802	280	50,082
6. Maintenance	30,096	7,366	14,263	51,725	0	51,725	1,805	53,530
7. Other (specify)*	0	0	0	0	0	0	208	208
8. Total General Services	261,026	167,866	65,166	494,058	0	494,058	1,165	495,223
9. Medical Director	0	0	14,000	14,000	0	14,000	0	14,000
10. Nursing & Medical Records	745,035	55,115	4,111	804,261	0	804,261	13	804,274
10a. Therapy	0	0	118,371	118,371	0	118,371	0	118,371
11. Activities	31,205	661	2,380	34,246	0	34,246	-7,216	27,030
12. Social Services	26,433	0	0	26,433	0	26,433	0	26,433
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	802,673	55,776	138,862	997,311	0	997,311	-7,203	990,108
17. Administrative	0	0	216,000	216,000	0	216,000	-164,440	51,560
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,059	8,059	0	8,059	97,808	105,867
20. Fees, Subscriptions & Promotion	0	0	5,766	5,766	0	5,766	746	6,512
21. Clerical & General Office	26,476	3,899	8,292	38,667	0	38,667	67,023	105,690
22. Employee Benefits & Payroll	0	0	176,175	176,175	0	176,175	-21	176,154
23. Inservice Training & Education	0	0	0	0	0	0	74	74
24. Travel and Seminar	0	0	0	0	0	0	4	4
25. Other Admin. Staff Trans	0	0	18,294	18,294	0	18,294	3,412	21,706
26. Insurance-Prop.Liab.Malpractice	0	0	23,166	23,166	0	23,166	659	23,825
27. Other (specify)*	0	0	0	0	0	0	4,228	4,228
28. Total General Adminis	26,476	3,899	455,752	486,127	0	486,127	9,493	495,620
29. Total General Administrative	1,090,175	227,541	659,780	1,977,496	0	1,977,496	3,455	1,980,951
30. Depreciation	0	0	26,185	26,185	0	26,185	29,460	55,645
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	36,384	36,384
32. Interest	0	0	6,358	6,358	0	6,358	106,996	113,354
33. Real Estate	0	0	19,768	19,768	0	19,768	296	20,064

34. Rent - Facility & Grounds		0	0	100,486	100,486	0	100,486	-100,486	0
35. Rent - Equipment & Vehicles		0	0	13,495	13,495	0	13,495	546	14,041
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	166,292	166,292	0	166,292	73,196	239,488
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	48,890	0	48,890	0	48,890	0	48,890
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	141,657	141,657	0	141,657	0	141,657
43. Other (specify):*		31,625	777	68,386	100,788	0	100,788	-100,788	0
44. Total Special Cost Ce		31,625	49,667	210,043	291,335	0	291,335	-100,788	190,547
45. Grand Total		1,121,800	277,208	1,036,115	2,435,123	0	2,435,123	-24,137	2,410,986

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	675	675
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	661,449	676,421
4. Supply Inventory	7,784	7,784
5. Short-Term Investments	0	0
6. Prepaid Insurance	21,905	21,905
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	791,923	791,923
9. Other (specify):	0	47,004
10. Total current assets	1,483,736	1,545,712
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	1,065,795
15. Leasehold Improvements, Historical Cost	0	84,887
16. Equipment, at Historical Cost	0	265,702
17. Accumulated Depreciation (book methods)	0	-644,231
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	36,384
21. Restricted Funds	17,968	85,413
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	17,968	952,450
25. Total Assets	1,501,704	2,498,162
CURRENT LIABILITIES		
26. Accounts Payable	1,452,456	1,452,456
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	14,256	14,256
31. Accrued Taxes Payable	4,261	4,261
32. Accrued Real Estate Taxes	19,704	19,704
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	39,044	39,044

37. Other Current Liabilities (specify):	167,151	167,151
38. Total Current Liabilities	1,696,872	1,696,872
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,988,194
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	3,890	28,797
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,890	2,016,991
46.Total Liabilities	1,700,762	3,713,863
47.Total Equity	-199,058	-1,215,701
48.Total Liabilities and Equity	1,501,704	2,498,162

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,400,829
2. Discounts and Allowances for all Levels	-145,819
Subtotal - Inpatient Care	2,255,010
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	179,205
7. Oxygen	85
Subtotal - Anciliary Revenue	179,290
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	4,930
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	89,957
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	4,533
21. Other Medical Services	1,130
22. Laundry	0
Subtotal - Other Operating Revenue	100,550
24. Contributions	0
25. Interest and Other Investments Income	6,780
Subtotal - Non-Operating Revenue	6,780
27. Other Revenue (specify):	0
28. Other Revenue (specify):	7,374
Subtotal - Other Revenue	7,374
30. Total Revenue	2,549,004
31. General Services	455,165
32. Health Care	910,211
33. General Administration	351,937
34. Ownership	140,808

35.	Special Cost Centers	87,560
35.	Provider Participation Fee	174,134
37.	Other	0
40.	Total Expenses	2,119,815
41.	Income Before Income Taxes	429,189
42.	Income Taxes	0
43.	Net Income or Loss for the Year	429,189

Enter Cost Center Expenses **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 5/20/2014 02:09:54 PM

HSA Number: 2 Name: **Countryview Care Ctr Macomb**

Cost report period From: 1/1/2013 To: 12/31/2013 Base Number: 456

If this is an ICF/DD 16 facility, enter a 1 in cell C6 N

Licensed bed days: 22,630 Occupancy: 18,704 Pct. of occupancy: 82.65%

Illinois Public Aid Support Rate: $

Genl Services Salary/Wage:	261,026	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage:	26,476	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage:	1,121,800	Col 1, Line 44 ---Audit Adj:	
Employee Benefits:	176,154	Col 8, Line 22 ---Audit Adj:	
Total General Services:	495,223	Col 8, Line 8 ---Audit Adj:	
Total General Admin:	495,620	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month =	13	divided by 2 =
Beginning Day + Ending Day =	32	divided by 60.8 =
Beginning Year + Ending Year =	226	multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

$261,026
$1,121,800
23.2685%
$176,154

$40,988
$495,223
$536,211

$26,476
$1,121,800
2.3601%

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

	$176,154
	$4,157
	$495,620
	$176,154
	$323,623
	6.5
	0.526315789
	1356
	1363.026316
	907.00
	456
	1
	1
	$536,211
	1
	$536,211

$323,623	
1	
	$323,623
	$859,834
$44.13	
$859,834	
18,704	
$45.97	
22,630	
0.93	
21,046	
18,704	
2,342	
781	
18,704	
19,485	

$859,834
19485

$44.13

$47.44
$44.13

$3.31

0.5

$1.66

$44.13

45.79

$47.44
$44.13

$3.31

	0.5
	$1.66
	3.795
	$1.660
	$44.13
	$45.79
	$45.79
	$47.44
	$39.95

F/DD 16 Facilities)
rcentiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655