

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0040931</u></p> <p>Facility Name: <u>COUNTRYSIDE CARE CENTRE</u></p> <p>Address: <u>2330 W. GALENA</u> <u>AURORA</u> <u>60506</u> <small>Number City Zip Code</small></p> <p>County: <u>KANE</u></p> <p>Telephone Number: <u>(630) 896-4686</u> Fax # <u>(630) 896-7868</u></p> <p>IDPA ID Number: <u>36-3961908</u></p> <p>Date of Initial License for Current Owners: <u>07/01/94</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>SHAEL BELLOWS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MANAGEMENT CONSULTANT</u></td> <td></td> </tr> <tr> <td></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>BOB KAGDA PARTNER</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>SHAEL BELLOWS</u>			(Title) <u>MANAGEMENT CONSULTANT</u>			(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	Paid Preparer	(Print Name and Title) <u>BOB KAGDA PARTNER</u>			(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>			(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	40,515	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	4,462	1,833	7,447	13,742	8
9	SNF/PED					9
10	ICF	36,039	14,745	2,697	53,481	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,501	16,578	10,144	67,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.12%

D. How many bed-hold days during this year were paid by Public Aid? 146 (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 NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 146 and days of care provided 3,188

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	305,432	26,962	12,206	344,600		344,600	(1,839)	342,761		1
2	Food Purchase		271,016		271,016		271,016	(2,263)	268,753		2
3	Housekeeping	202,596	42,820	0	245,416		245,416	1,784	247,200		3
4	Laundry	89,138	25,446	3,630	118,214		118,214	(1,384)	116,830		4
5	Heat and Other Utilities			199,925	199,925		199,925	0	199,925		5
6	Maintenance	44,511	50,800	57,507	152,818		152,818	1,009	153,827		6
7	Other (specify):*			33,955	33,955		33,955	0	33,955		7
8	TOTAL General Services	641,677	417,044	307,223	1,365,944	0	1,365,944	(2,693)	1,363,251		8
	B. Health Care and Programs										
9	Medical Director	0		14,744	14,744		14,744	0	14,744		9
10	Nursing and Medical Records	2,979,457	147,483	358,437	3,485,377		3,485,377	(6,693)	3,478,684		10
10a	Therapy	102,415		0	102,415		102,415	0	102,415		10a
11	Activities	128,541	7,472	12,432	148,445		148,445	(1,156)	147,289		11
12	Social Services	56,713		1,265	57,978		57,978	0	57,978		12
13	Nurse Aide Training			465	465		465	0	465		13
14	Program Transportation			170	170		170	0	170		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	3,267,126	154,955	387,513	3,809,594	0	3,809,594	(7,849)	3,801,745		16
	C. General Administration										
17	Administrative	209,022		711,849	920,871		920,871	(697,631)	223,240		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			207,817	207,817		207,817	11,434	219,251		19
20	Dues, Fees, Subscriptions & Promotions			111,588	111,588		111,588	(70,935)	40,653		20
21	Clerical & General Office Expenses	155,030	62,048	67,481	284,559		284,559	116,915	401,474		21
22	Employee Benefits & Payroll Taxes			647,614	647,614		647,614	0	647,614		22
23	Inservice Training & Education			13,604	13,604		13,604	0	13,604		23
24	Travel and Seminar			191	191		191	12,925	13,116		24
25	Other Admin. Staff Transportation			4,749	4,749		4,749	0	4,749		25
26	Insurance-Prop.Liab.Malpractice			13,228	13,228		13,228	164,030	177,258		26
27	Other (specify):*			33,950	33,950		33,950	(33,950)	0		27
28	TOTAL General Administration	364,052	62,048	1,812,071	2,238,171	0	2,238,171	(497,212)	1,740,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,272,855	634,047	2,506,807	7,413,709	0	7,413,709	(507,754)	6,905,955		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 COUNTRYSIDE CARE CENTRE

#0040931

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			119,681	119,681		119,681	140,201	259,882		30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0		31
32	Interest			191,799	191,799		191,799	323,156	514,955		32
33	Real Estate Taxes			96,812	96,812		96,812	0	96,812		33
34	Rent-Facility & Grounds			899,269	899,269		899,269	(889,981)	9,288		34
35	Rent-Equipment & Vehicles			28,624	28,624		28,624	8,360	36,984		35
36	Other (specify):*			0	0		0	0	0		36
37	TOTAL Ownership			1,336,185	1,336,185	0	1,336,185	(418,264)	917,921		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			0	0		0	0	0		38
39	Ancillary Service Centers		245,213	327,681	572,894		572,894	0	572,894		39
40	Barber and Beauty Shops			0	0		0	0	0		40
41	Coffee and Gift Shops			0	0		0	0	0		41
42	Provider Participation Fee			114,427	114,427		114,427	0	114,427		42
43	Other (specify):*			0	0		0	0	0		43
44	TOTAL Special Cost Centers	0	245,213	442,108	687,321	0	687,321	0	687,321		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,272,855	879,260	4,285,100	9,437,215	0	9,437,215	(926,018)	8,511,197		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,808)	30		9
10	Interest and Other Investment Income	(23,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,263)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(2,190)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,977)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(2,481)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,950)	27		24
25	Fund Raising, Advertising and Promotional	(49,082)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(18,214)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(34,411)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (233,461)		\$ 0	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(692,557)	PG.6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (692,557)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (926,018)		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.

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1150	6	1
2	VACATION ACCRUAL	(1,839)	1	2
3	VACATION ACCRUAL	1,784	3	3
4	VACATION ACCRUAL	(1,384)	4	4
5	VACATION ACCRUAL	(141)	6	5
6	VACATION ACCRUAL	(19,065)	10	6
7	VACATION ACCRUAL	(1,156)	11	7
8	VACATION ACCRUAL	(4,643)	17	8
9	VACATION ACCRUAL	(9,117)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(34,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2001

Ending:

12/31/2001**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	(1,839)	0	0	0	0	0	0	0	0	0	0	(1,839)	1
2	Food Purchase	(2,263)	0	0	0	0	0	0	0	0	0	0	(2,263)	2
3	Housekeeping	1,784	0	0	0	0	0	0	0	0	0	0	1,784	3
4	Laundry	(1,384)	0	0	0	0	0	0	0	0	0	0	(1,384)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,009	0	0	0	0	0	0	0	0	0	0	1,009	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,693)	0	0	0	0	0	0	0	0	0	0	(2,693)	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	(19,065)	12,372	0	0	0	0	0	0	0	0	0	(6,693)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,156)	0	0	0	0	0	0	0	0	0	0	(1,156)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	(20,221)	12,372	0	0	0	0	0	0	0	0	0	(7,849)	16
	C. General Administration													
17	Administrative	(4,643)	(692,988)	0	0	0	0	0	0	0	0	0	(697,631)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,481)	6,000	7,915	0	0	0	0	0	0	0	0	11,434	19
20	Fees, Subscriptions & Promotions	(73,273)	2,338	0	0	0	0	0	0	0	0	0	(70,935)	20
21	Clerical & General Office Expenses	(11,307)	127,511	711	0	0	0	0	0	0	0	0	116,915	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,925	0	0	0	0	0	0	0	0	0	12,925	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,150	159,880	0	0	0	0	0	0	0	0	164,030	26
27	Other (specify):*	(33,950)	0	0	0	0	0	0	0	0	0	0	(33,950)	27
28	TOTAL General Administration	(125,654)	(540,064)	168,506	0	(497,212)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(148,568)	(527,692)	168,506	0	(507,754)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2001 Ending:12/31/2001

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(61,808)	6,642	195,367	0	0	0	0	0	0	0	0	140,201	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,085)	0	346,241	0	0	0	0	0	0	0	0	323,156	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,288	(899,269)	0	0	0	0	0	0	0	0	(889,981)	34
35	Rent-Equipment & Vehicles	0	8,360	0	0	0	0	0	0	0	0	0	8,360	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(84,893)	24,290	(357,661)	0	(418,264)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(233,461)	(503,402)	(189,155)	0	(926,018)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		FIRST HEALTH CARE ASSOCIATES, LTD. (DIVISION OF FHC ENTERPRISE, INC.)	ROSEMONT	MANAGEMENT/CONSULTANT
				COUNTRYSIDE HEALTHCARE CENTRE	ROSEMONT, IL	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 NURSING	\$	FHC ENTERPRISES INC.		\$ 12,372	\$ 12,372	1
2	V	17 ADMINISTRATIVE	711,849	MR. BELLOWS WONS 1.5% OF THIS FACILITY AND 100% OF FHC ENTERPRISES		18,861	(692,988)	2
3	V	19 PROFESSIONAL FEES				6,000	6,000	3
4	V	20 DUES & SUBSCRIPTIONS				2,338	2,338	4
5	V	21 CLERICAL				127,511	127,511	5
6	V	24 TRAVEL				12,925	12,925	6
7	V	26 INSURANCE				4,150	4,150	7
8	V	30 DEPRECIATION				6,642	6,642	8
9	V	34 RENT				9,288	9,288	9
10	V	35 RENT-EQUIPMENT & VEH				8,360	8,360	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 711,849			\$ 208,447	\$ * (503,402)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 RENT	\$ 899,269	COUNTRYSIDE HEALTHCARE CENTRE		\$	\$ (899,269)	15
16	V	19 ACCOUNTING FEES		" "		7,500	7,500	16
17	V	19 LEGAL FEES		" "		340	340	17
18	V	19 OTHER PROFESSIONAL		" "		75	75	18
19	V	21 BANK CHARGES		" "		711	711	19
20	V	26 GENERAL INSURANCE		" "		136,419	136,419	20
21	V	26 MORTGAGE INSURANCE		" "		23,461	23,461	21
22	V	30 DEPRECIATION - BLDG/IMP		" "		186,607	186,607	22
23	V	30 DEPRECIATION - EQP/FURN		" "		8,760	8,760	23
24	V	32 AMORTIZATION - MTG COST		" "		2,972	2,972	24
25	V	32 INTEREST - MORTGAGE		" "		343,269	343,269	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		\$ 899,269			\$ 710,114	\$ * (189,155)	39

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								\$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	1.5%	SEE ATTACHED	2.5	13.21	SALARY	18,861	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,861		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 COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2001

Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization FHC ENTERPRISES INC.
 Street Address 10700 W. HIGGINS ROAD, STE. 300
 City / State / Zip Code ROSEMONT, IL 60018
 Phone Number (847) 296-9625
 Fax Number (847) 298-0824

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	\$ 92,369	\$ 67,223	\$ 12,372	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	67,223	18,861	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800	67,223	6,000	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462	67,223	2,338	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659	67,223	17,500	5
6	21	CLERICAL	HOURS	1	1	110,011	110,016	1	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528	67,223	12,925	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995	67,223	4,150	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603	67,223	6,642	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364	67,223	9,288	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438	67,223	8,360	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 845,046	\$ 343,202	\$ 208,447	25

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE**

0040931

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE				\$	\$			\$	1										
2	MIDLAND	X	MORTGAGE	VARIES	10/97	4,826,200	4,680,969	10/32	0.0745	343,269	2									
3	MIDLAND	X	LOAN COST	35 YR AMORT	10/97	104,006	91,127			2,972	3									
4											4									
5											5									
Working Capital																				
6	AMERICAN NATIONAL BANK	X	LINE OF CREDIT	VARIES	12/96	265,000	805,000	DEMAND	PRIME +	70,290	6									
7	LOAN FROM PARTNERS	X	WORKING CAPITAL	VARIES	06/99	108,600	134,166	DEMAND	PRIME +	10,590	7									
8	RELATER PARTIES	X	WORKING CAPITAL	VARIES	12/98	498,989		DEMAND	PRIME +	110,919	8									
9	TOTAL Facility Related					\$ 5,802,795	\$ 5,711,262			\$ 538,040	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0	14									
15	TOTALS (line 9+line14)					\$ 5,802,795	\$ 5,711,262			\$ 538,040	15									

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

(See instructions.)

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

(See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 93,120	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.)		\$ 94,448	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,328	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 95,484	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ 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.		\$ 96,812	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	88,981	8
	1997	87,583	9
	1998	89,211	10
	1999	92,112	11
	2000	94,448	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.			
		FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2000	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-19-176-009</u>	<u>NURSING HOME</u>	\$ <u>94,448.14</u>	\$ <u>94,448.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>94,448.14</u>	\$ <u>94,448.14</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CNST Number of Stories 2

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	130,679	1981	\$ 98,000	1
2	754 BASIS ADJ.		1982	16,345	2
3	TOTALS	130,679		\$ 114,345	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	2 FOR OHF USE ONLY	3 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	209		1981		\$ 2,111,156	\$	30	\$ 70,059	\$ 70,059	\$ 1,430,032	4
5											5
6	754 BASIS AJ			1992	403,542	12,811	31.5	12,811		121,705	6
7											7
8											8
	Improvement Type**										
9	*****REALTED PARTY - COUNTRYSIDE HEALTHCARE										
10				1982	40,076		15			40,076	10
11				1983	26,282		15			26,282	11
12				1984	76,250	1,990	20	3,813	1,823	66,717	12
13				1985	6,644	349	20	332	(17)	5,478	13
14				1986	1,609	85	15	107	22	1,656	14
15				1987	36,433	1,157	20	1,822	665	26,419	15
16				1988	1,594	106	15	106		1,431	16
17				1988	5,837	185	31.5	185		2,444	17
18				1989	51,879	1,647	31.5	1,647		20,931	18
19				1990	7,000	222	31.5	222		2,553	19
20				1990	7,930	529	15	529		6,083	20
21				1991	24,486	777	20	1,224	447	12,860	21
22				1992	43,773	1,390	31.5	1,390		13,069	22
23				1993	13,286	421	31.5	421		3,728	23
24				1993	40,598	1,041	39	1,041		8,630	24
25				1994	221,766	5,494	39	5,494		39,422	25
26				1994	55,030	4,167	15	4,167		31,249	26
27				1995	32,836	842	39	842		5,826	27
28				1995	31,634	811	39	811		4,355	28
29				1995	15,211	390	39	390		2,110	29
30				1996	4,300	110	39	110		647	30
31				1996	3,400	87	39	87		446	31
32				1996	8,584	220	39	220		1,109	32
33											33
34											34
35											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 COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	REMOVE & REPLACE HVAC ROOF UNITS	1998	\$ 28,363	\$ 727	39	\$ 727	\$	\$ 2,393	37
38	ROOF REPAIRS - PATCHING	1998	6,500	167	39	167		647	38
39	STAINLESS DUCTWORK - KITCHEN EXHAUST	1998	3,987	102	39	102		404	39
40	BOILER	1998	6,556	168	39	168		609	40
41	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	58,243	2,118	27.5	2,118		6,266	41
42	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		2,876	42
43	REMODEL KITCHEN/WALLCOVERINGS/DRY WALL	1999	11,104	404	27.5	404		1,128	43
44	DINING RMS/WASHROOM-REMODEL/NEW ROOF	1999	165,984	6,035	27.5	6,035		16,346	44
45	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		3,720	45
46	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		2,420	46
47	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624	27.5	4,624		11,368	47
48	IRRIGATION SYSTEM/BTY STATIONS	1999	26,058	947	27.5	947		2,249	48
49	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661	27.5	30,661		67,714	49
50	REMODEL-OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		5,160	50
51	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		372	51
52	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336	27.5	2,336		3,797	52
53	ELEVATOR OPERATING PANEL	2000	4,490	163	27.5	163		265	53
54	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		403	54
55	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		454	55
56	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		264	56
57	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		4,148	57
58	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		404	58
59	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		1,092	59
60	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		291	60
61	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		1,673	61
62	GENERATORS	2000	92,626	3,368	27.5	3,368		4,070	62
63	LANDSCAPING	2000	12,625	842	15	842		1,262	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		2,957	64
65	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		639	65
66	AIR FREE LINT FILTER	2000	1,399	51	27.5	51		62	66
67	NEW ROOF	2000	20,995	763	27.5	763		859	67
68	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		4,238	68
69	ROOF REPAIRS	2000	3,300	120	27.5	120		135	69
70	TOTAL (lines 4 thru 69)		\$ 5,281,939	\$ 107,837		\$ 180,836	\$ 72,999	\$ 2,025,943	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,281,939	\$ 107,837		\$ 180,836	\$ 72,999	\$ 2,025,943	1
2									2
3	ROOF REPAIR & METACALK FIRE STOP	2000	11,211	408	27.5	408		425	3
4	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		278	4
5	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		4,131	5
6	REMOVE/INSTL FLOORING & DRYWALL-KITCHEN, LNDR	2001	16,675	531	27.5	531		531	6
7	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	105	27.5	105		105	7
8	INSTALL HYDRAULIC PUMPING UNIT-KITCHEN ELEVATOR	2001	7,495	216	27.5	216		216	8
9	REPLACE WATER CLOSETS & FLUSH VALVES-KITCHEN	2001	7,737	176	27.5	176		176	9
10	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	57	27.5	57		57	10
11	PUMP FOR IRRIGATION SYSTEM	2001	1,825	36	27.5	36		36	11
12	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	10	27.5	10		10	12
13									13
14									14
15									15
16			ADJ TO SL	72,999			(72,999)		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,456,253	\$ 186,607		\$ 186,607	\$ 0	\$ 2,031,908	34

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

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE**

0040931

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 669,126	\$ 107,322	\$ 53,798	\$ (53,524)	3-15 YRS	\$ 185,951	71
72	Current Year Purchases	79,908	12,359	4,075	(8,284)	3-15 YRS	4,075	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	739,687	15,402	15,402	0		718,899	74
75	TOTALS	\$ 1,488,721	\$ 135,083	\$ 73,275	\$ (61,808)		\$ 908,925	75

D. Vehicle Depreciation (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				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 7,059,319	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 321,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,882	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,808)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,940,833	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 21,699

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY USE</u>	<u>99 DODGE RAM PR 2W</u>	\$ <u>625.00</u>	\$ <u>6,925</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 625.00	\$ 6,925	21

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>99</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>48</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ 357	\$	\$ 357
2 Books and Supplies		108		108
3 Classroom Wages (a)				0
4 Clinical Wages (b)				0
5 In-House Trainer Wages (c)				0
6 Transportation				0
7 Contractual Payments				0
8 Nurse Aide Competency Tests				0
9 TOTALS	\$ 0	\$ 465	\$ 0	\$ 465
10 SUM OF line 9, col. 1 and 2 (e)	\$ 465			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 121,088	\$		\$ 121,088	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			24,529			24,529	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			182,064			182,064	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				110,652		110,652	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY & RENTALS & Other (specify): MEDICAL SUPPLIES	39-2					134,561		134,561	13
14	TOTAL			\$		\$ 327,681	\$ 245,213		\$ 572,894	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931Report Period Beginning: 01/01/2001Ending: 12/31/2001**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2001

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 16,822	\$ 111,877	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>33,964</u>)	2,389,416	2,389,416	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,863	207,744	6
7	Other Prepaid Expenses	1,594	1,594	7
8	Accounts Receivable (owners or related parties)	65,803	181,339	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		47,816	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,509,498	\$ 2,939,786	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,883	1,883	12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		2,941,553	15
16	Equipment, at Historical Cost	749,033	1,387,680	16
17	Accumulated Depreciation (book methods)	(442,740)	(3,369,698)	17
18	Deferred Charges	2,050	93,177	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>REPLACEMENT RESERVES</u>		415,194	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 310,226	\$ 3,678,945	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,819,724	\$ 6,618,731	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 402,636	\$ 506,867	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	149,847	149,847	28
29	Short-Term Notes Payable	120,627	412,603	29
30	Accrued Salaries Payable	108,549	108,549	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,391	13,391	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,484	32
33	Accrued Interest Payable	106	106	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	426,710	426,710	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,221,866	\$ 1,713,557	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,724,921	2,724,921	39
40	Mortgage Payable		4,680,969	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,724,921	\$ 7,405,890	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,946,787	\$ 9,119,447	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,127,063)	\$ (2,500,716)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,819,724	\$ 6,618,731	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (676,445)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (676,444)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(450,619)	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)	\$ (450,619)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,127,063)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931Report Period Beginning: 01/01/2001Ending: 12/31/2001

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,963,205	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,963,205	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	196	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	110	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income****	23,085	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,085	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,986,596	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,365,944	31
32	Health Care	3,809,594	32
33	General Administration	2,238,171	33
	B. Capital Expense		
34	Ownership	1,336,185	34
	C. Ancillary Expense		
35	Special Cost Centers	572,894	35
36	Provider Participation Fee	114,427	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,437,215	40
41	Income before Income Taxes (line 30 minus line 40)**	(450,619)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (450,619)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

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

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

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,949	2,118	\$ 72,304	\$ 34.14	1
2	Assistant Director of Nursing	3,966	4,267	126,517	29.65	2
3	Registered Nurses	27,257	30,064	725,603	24.14	3
4	Licensed Practical Nurses	14,253	15,397	332,220	21.58	4
5	Nurse Aides & Orderlies	105,399	111,970	1,528,178	13.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,101	6,818	102,415	15.02	8
9	Activity Director	2,054	2,286	27,543	12.05	9
10	Activity Assistants	10,565	11,343	100,998	8.90	10
11	Social Service Workers	3,466	3,719	56,713	15.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,177	13,693	175,064	12.78	14
15	Cook Helpers/Assistants	16,791	17,578	130,368	7.42	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,178	44,511	20.44	17
18	Housekeepers	21,249	23,458	202,596	8.64	18
19	Laundry	9,257	10,266	89,138	8.68	19
20	Administrator	1,955	2,182	121,098	55.50	20
21	Assistant Administrator	3,223	3,489	87,924	25.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,858	9,536	155,030	16.26	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	9,725	10,610	194,635	18.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	260,246	280,972	\$ 4,272,855 *	\$ 15.21	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	248	\$ 12,206	1-3	35
36	Medical Director	91	14,744	9-3	36
37	Medical Records Consultant	32	1,392	10-3	37
38	Nurse Consultant	814	28,095	10-3	38
39	Pharmacist Consultant	325	2,600	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	41	2,228	11-3	44
45	Social Service Consultant	23	1,265	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,574	\$ 62,530		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,975	\$ 188,770	10-3	50
51	Licensed Practical Nurses	3,715	137,528	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7,690	\$ 326,298		53

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								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1999	\$ 9,371	3	\$	\$ 1,562	\$ 3,124	\$ 3,124	\$ 151	\$	\$	\$	\$
2	PAINT/DECORATING	2001	2,369					395	790	790	394		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,740		\$	\$ 1,562	\$ 3,124	\$ 3,519	\$ 941	\$ 790	\$ 394	\$	\$

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL. COUNCIL LONG TERM CARE - \$10701
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,353 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,427
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 of Public Aid, 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? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	12,206
	REPAIRS & MAINTENANCE	0
		0
		12,206
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,630
		0
		3,630
5	HEAT & OTHER UTILITIES	
	GAS HEAT	62,564
	ELECTRICITY	77,456
	WATER	59,905
	CABLE TV - LOBBY	0
		0
		199,925
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,919
	PAINTING & DECORATING	2,369
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	28,850
	ELEVATOR MAINTENANCE & REPAIR	4,078
	OUTSIDE LABOR	2,751
	EXTERMINATING SERVICE	6,032
	FIRE SERVICE	1,418
	DEFERRED PAINTING & DECORATING	3,090
		0
		0
		57,507
7	OTHER	
	SCAVENGER	32,299
	SECURITY SERVICE	1,656
		33,955
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,744
		14,744

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	326,298
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	52
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,392
	PHARMACY CONSULTANT XVIII B 39-2	2,600
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	28,095
		0
		0
		358,437
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	10,204
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,228
		0
		12,432
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,265
		0
		1,265
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	465
		465

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	170
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	711,849
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	18,792
	ADMINISTRATIVE CONSULTANTS XIX C	17,646
	PROFESSIONAL FEES XIX C	171,379
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	207,817
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	49,082
	EMPLOYEE WANT ADS XIX F	23,564
	CONTRIBUTIONS VI 20 XIX F	947
	DUES & SUBSCRIPTIONS XIX F	8,227
	LICENSES & PERMITS XIX F	5,360
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	18,214
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,030
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,164
21	CLERICAL & GENERAL OFFICE EXPENSES	111,588
	BANK CHARGES	21,729
	EQUIPMENT REPAIR & MAINTENANCE	4,878
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,190
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	36,863
	MESSENGER SERVICE	1,821
		0
		67,481

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	322,403
	UNEMPLOYMENT COMPENSATION XIX D	36,503
	WORKERS COMPENSATION INSURANC XIX D	64,882
	HOSPITALIZATION INSURANCE XIX D	201,957
	EMPLOYEE BENEFITS - OTHER XIX D	11,659
	EMPLOYEE PHYSICAL EXAMS XIX D	352
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,858
	CHICAGO HEAD TAX XIX D	0
		647,614
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	13,604
		13,604
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	191
		0
		0
		191
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,749
		4,749
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	13,228
		13,228
27	OTHER	
	BAD DEBTS VI 24	33,950
		0
		33,950

GRAND TOTAL COLUMN 3 OTHER

2,506,807

COUNTRYSIDE CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION
 12/31/2001

TOTAL FOOD PURCHASE	271,016	PATIENT MEALS	201669
LESS SALES TAX	(2,263)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	273279	TOTAL MEALS/YEAR	201669
TOTAL PATIENT CENSUS	67,223	NET FOOD	273279
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	201669

TOTAL PATIENT MEALS	201669	COST PER MEAL	1.36
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

COUNTRYSIDE CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									8,325,224	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	3,809,594	647,614	632,114	118,214	615,616	1,590,557	114,427	1,336,185		4,272,855
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	7,812		779			20,033		(28,624)		
CABLE TV			0			0				
CONTRACT NURSING										326,298
INTEREST INCOME							(23,085)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		(352)				352				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(711,849)		711,849		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(33,950)	33,950			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSIFIED SALARIES	(76,605)	0	0	0	0	76,605	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(65,087)	0		
BENEFITS REBILLED/OTHER UNCLASS.	0	0	0	0	0	0	(110)	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	(196)	0		
TOTAL COSTS	3,740,801	647,262	632,893	118,214	615,616	941,748	59,899	2,019,410	8,775,843	4,599,153
PER FINANCIAL STATEMENTS	3,740,801	647,262	632,893	118,214	615,616	941,748	59,899	2,019,410	(450,619)	4,599,153
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									(450,619)	

COUNTRYSIDE CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		76,285			76494		(209)	76285			
CENSUS DAYS		67,223			65953		1,270	66127			
OCCUPANCY %		88.12%			86.22%			86.68%			
SALARIES											
TOTAL General Services	8-1	641,677	7.54%	9.55	631923	8.30%	9.58	9,754	663552	10.69%	10.03
Social Services	12-1	56,713	0.67%	0.84	54079	0.71%	0.82	2,634	45124	0.73%	0.68
TOTAL Health Care and Programs	16-1	3,267,126	38.39%	48.60	2853912	37.51%	43.27	413,214	2283550	36.80%	34.53
Clerical & General Office Expenses	21-1	155,030	1.82%	2.31	142168	1.87%	2.16	12,862	81332	1.31%	1.23
TOTAL General Administration	28-1	364,052	4.28%	5.42	282285	3.71%	4.28	81,767	183222	2.95%	2.77
TOTAL Operation Expense	29-1	4,272,855	50.20%	63.56	3768120	49.52%	57.13	504,735	3130324	50.45%	47.34
ADJUSTED TOTALS											
Food	2-8	268,753	3.16%	4.00	238660	3.14%	3.62	30,093	237677	3.83%	3.59
Heat and Other Utilities	5-8	199,925	2.35%	2.97	170133	2.24%	2.58	29,792	142031	2.29%	2.15
Maintenance	6-8	153,827	1.81%	2.29	152148	2.00%	2.31	1,679	149783	2.41%	2.27
TOTAL General Services	8-8	1,363,251	16.02%	20.28	1316464	17.30%	19.96	46,787	1270453	20.47%	19.21
Administrative	17-8	223,240	2.62%	3.32	136734	1.80%	2.07	86,506	119858	1.93%	1.81
Directors Fees	18-8	0	0.00%	0.00				0	0	0.00%	0.00
Professional Services	19-8	219,251	2.58%	3.26	317846	4.18%	4.82	(98,595)	217679	3.51%	3.29
Fees, Subscriptions, Promotions	20-8	40,653	0.48%	0.60	43563	0.57%	0.66	(2,910)	28636	0.46%	0.43
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	200	0.00%	0.00
License Fee-Other	Pg21	5,360	0.06%	0.08	369	0.00%	0.01	4,991	600	0.01%	0.01
Clerical & General Office Expenses	21-8	401,474	4.72%	5.97	404455	5.32%	6.13	(2,981)	322699	5.20%	4.88
Employee Benefits & Payroll Taxes	22-8	647,614	7.61%	9.63	519209	6.82%	7.87	128,405	517248	8.34%	7.82
Payroll Taxes	Pg21	358,906	4.22%	5.34	319087	4.19%	4.84	39,819	265546	4.28%	4.02
W/C Insurance	Pg21	64,882	0.76%	0.97	55799	0.73%	0.85	9,083	1036	0.02%	0.02
Health Insurance	Pg21	201,957	2.37%	3.00	115217	1.51%	1.75	86,740	228629	3.68%	3.46
Inservice Training & Education	23-8	13,604	0.16%	0.20	14607	0.19%	0.22	(1,003)	11104	0.18%	0.17
Travel and Seminar	24-8	13,116	0.15%	0.20	13420	0.18%	0.20	(304)	10436	0.17%	0.16
Other Admin. Staff Transportation	25-8	4,749	0.06%	0.07	4341	0.06%	0.07	408	7193	0.12%	0.11
Insurance-Prop.Liab.Malpractice	26-8	177,258	2.08%	2.64	134316	1.77%	2.04	42,942	81028	1.31%	1.23
Other (specify):*	27-8	0	0.00%	0.00				0	0	0.00%	0.00
TOTAL General Administration	28-8	1,740,959	20.45%	25.90	1588491	20.88%	24.09	152,468	1315881	21.21%	19.90
TOTAL Operation Expense	29-8	6,905,955	81.14%	102.73	6215367	81.68%	94.24	690,588	5155774	83.09%	77.97
Real Estate Taxes	33-3	96,812	1.14%	1.44	95040	1.25%	1.44	1,772	90855	1.46%	1.37
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	8,511,197	100.00%	126.61	7609227	100.00%	115.37	901,970	6205315	100.00%	93.84
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2609029.017	30.65%	38.81	2511715	33.01%	38.08	97,314	2209005	35.60%	33.41

COUNTRYSIDE CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.

Page 3 Column 3 - Other is completely scheduled.

Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.

Total Adj on Page 4 Line 45-7 = Page 5 Line 37.

Deferred maint. adj. on Page 5A Line 1 consists of 3519 from Page 22 and -2369 from Page 3 Line 6-3.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.

Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-346241

Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.

Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.

Deprn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-202009

Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.

Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.

Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.

Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.

Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.

Page 17 Assets = Liabilities & Capital.

Net income on Page 18 Line 7-1 = Page 19 Line 43-2.

Administrative Salaries on Page 3 Line 17-1 = Page 21-A.

Management fees on Page 3 Line 17-3 = Page 21-B.

Professional fees on Page 3 Line 19-3 = Page 21-C.

Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.

Dues, etc. on Page 3 Line 20-8 = Page 21-F.

Travel expenses on Page 3 Line 24-8 = Page 21-G.