

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,445	1,528	10,660	19,633	8
9	SNF/PED					9
10	ICF	42,893	8,806		51,699	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,338	10,334	10,660	71,332	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.41%

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

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
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 131 and days of care provided 5,900

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE** # **0040931** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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	344,744	26,460	21,640	392,844		392,844	(1,260)	391,584		1
2	Food Purchase		267,619		267,619	0	267,619	(3,511)	264,108		2
3	Housekeeping	291,960	47,071	0	339,031		339,031	(339)	338,692		3
4	Laundry	56,899	39,899	5,580	102,378	0	102,378	2,093	104,471		4
5	Heat and Other Utilities			240,712	240,712		240,712	0	240,712		5
6	Maintenance	50,183	56,522	35,082	141,787		141,787	1,128	142,915		6
7	Other (specify):*			44,343	44,343		44,343	0	44,343		7
8	TOTAL General Services	743,786	437,571	347,357	1,528,714	0	1,528,714	(1,889)	1,526,825		8
	B. Health Care and Programs										
9	Medical Director	0		15,000	15,000		15,000	0	15,000		9
10	Nursing and Medical Records	4,386,118	286,630	138,664	4,811,412		4,811,412	(109,657)	4,701,755		10
10a	Therapy	70,626		0	70,626		70,626	0	70,626		10a
11	Activities	122,414	6,756	16,522	145,692		145,692	(1,408)	144,284		11
12	Social Services	71,417		10,024	81,441		81,441	0	81,441		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	4,650,575	293,386	180,210	5,124,171	0	5,124,171	(111,065)	5,013,106		16
	C. General Administration										
17	Administrative	184,264		923,112	1,107,376		1,107,376	(936,851)	170,525		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			408,705	408,705		408,705	(220,698)	188,007		19
20	Dues, Fees, Subscriptions & Promotions			137,818	137,818		137,818	(109,455)	28,363		20
21	Clerical & General Office Expenses	212,843	54,493	58,522	325,858		325,858	187,694	513,552		21
22	Employee Benefits & Payroll Taxes			994,252	994,252	0	994,252	0	994,252		22
23	Inservice Training & Education			9,086	9,086		9,086	0	9,086		23
24	Travel and Seminar			595	595		595	13,311	13,906		24
25	Other Admin. Staff Transportation			8,327	8,327		8,327	0	8,327		25
26	Insurance-Prop.Liab.Malpractice			216,791	216,791		216,791	7,494	224,285		26
27	Other (specify):*			179,700	179,700		179,700	(179,700)	0		27
28	TOTAL General Administration	397,107	54,493	2,936,908	3,388,508	0	3,388,508	(1,238,205)	2,150,303		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,791,468	785,450	3,464,475	10,041,393	0	10,041,393	(1,351,159)	8,690,234		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	15,583
	REPAIRS & MAINTENANCE	6,057
		0
		21,640
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	5,580
		0
		5,580
5	HEAT & OTHER UTILITIES	
	GAS HEAT	75,814
	ELECTRICITY	77,094
	WATER	87,804
	CABLE TV - LOBBY	0
		0
		240,712
6	MAINTENANCE	
	GROUND MAINTENANCE	8,033
	PAINTING & DECORATING	1,961
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,436
	ELEVATOR MAINTENANCE & REPAIR	6,797
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,954
	FIRE SERVICE	2,901
		0
		0
		0
		0
		35,082
7	OTHER	
	SCAVENGER	42,029
	SECURITY SERVICE	2,314
		0
		0
		44,343
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,000
		15,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	10,618
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,504
	PHARMACY CONSULTANT XVIII B 39-2	2,400
	UTILIZATION REVIEW FEES XVIII B 46-2	6,000
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	118,142
		0
		0
		138,664
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	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	15,107
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,415
		0
		16,522
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	9,000
	SOCIAL WORKER XVIII B 45-2	1,024
		0
		10,024
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	923,112
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	39,702
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	369,003
		0
		408,705
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	86,837
	EMPLOYEE WANT ADS XIX F	9,785
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,522
	LICENSES & PERMITS XIX F	1,940
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	18,868
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,786
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,700
	PATIENT BACKGROUND CHECKS XIX F	3,380
		137,818
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	11,002
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	8,141
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	11
	TELEPHONE	36,977
	MESSENGER SERVICE	2,391
		0
		58,522

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	438,090
	UNEMPLOYMENT COMPENSATION XIX D	96,230
	WORKERS COMPENSATION INSURANC XIX D	128,886
	HOSPITALIZATION INSURANCE XIX D	309,844
	EMPLOYEE BENEFITS - OTHER XIX D	14,107
	EMPLOYEE PHYSICAL EXAMS XIX D	280
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	6,815
	CHICAGO HEAD TAX XIX D	0
		0
		994,252
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,086
		9,086
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	595
		595
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,327
		8,327
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	216,791
		216,791
27	OTHER	
	BAD DEBTS VI 24	179,700
		179,700

GRAND TOTAL COLUMN 3 OTHER

3,464,475

COUNTRYSIDE CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	267,619	PATIENT MEALS	213996
LESS SALES TAX	(3,511)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	264,108	TOTAL MEALS/YEAR	213996
TOTAL PATIENT CENSUS	71,332	NET FOOD	264108
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	213996

TOTAL PATIENT MEALS	213996	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

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	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			107,324	107,324		107,324	202,607	309,931		30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0		31
32	Interest			206,235	206,235		206,235	277,602	483,837		32
33	Real Estate Taxes			147,809	147,809		147,809	0	147,809		33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(718,813)	44,037		34
35	Rent-Equipment & Vehicles			27,293	27,293		27,293	9,631	36,924		35
36	Other (specify):* MTG INSURANCE				0		0	23,519	23,519		36
37	TOTAL Ownership			1,251,511	1,251,511	0	1,251,511	(205,454)	1,046,057		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers		452,484	915,764	1,368,248		1,368,248	0	1,368,248		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			113,333	113,333		113,333	0	113,333		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	452,484	1,029,097	1,481,581	0	1,481,581	0	1,481,581		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,791,468	1,237,934	5,745,083	12,774,485	0	12,774,485	(1,556,613)	11,217,872		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	(11,335)	30		9
10	Interest and Other Investment Income	(102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,511)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(8,141)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,786)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(8,162)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(179,700)	27		24
25	Fund Raising, Advertising and Promotional	(86,837)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(18,868)	20		28
29	Other-Attach Schedule	(61,583)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (384,025)		\$ 0	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	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)	(1,172,588)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,172,588)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,556,613)		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	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

ID# 0040931

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (291)	6	1
2	VACATION ACCRUAL	(1,260)	1	2
3	VACATION ACCRUAL	(339)	3	3
4	VACATION ACCRUAL	2,093	4	4
5	VACATION ACCRUAL	1,419	6	5
6	VACATION ACCRUAL	(29,056)	10	6
7	VACATION ACCRUAL	(1,408)	11	7
8	VACATION ACCRUAL	(14,595)	17	8
9	VACATION ACCRUAL	(9,443)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(3)	19	11
12	MARKETING CONSULTANT	(3,900)	19	12
13	MEDICARE B BILLING	(2,800)	19	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	(61,583)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,260)	0	0	0	0	0	0	0	0	0	0	(1,260)	1
2	Food Purchase	(3,511)	0	0	0	0	0	0	0	0	0	0	(3,511)	2
3	Housekeeping	(339)	0	0	0	0	0	0	0	0	0	0	(339)	3
4	Laundry	2,093	0	0	0	0	0	0	0	0	0	0	2,093	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,128	0	0	0	0	0	0	0	0	0	0	1,128	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,889)	0	0	0	0	0	0	0	0	0	0	(1,889)	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	(29,056)	0	0	(80,601)	0	0	0	0	0	0	0	(109,657)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,408)	0	0	0	0	0	0	0	0	0	0	(1,408)	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	(30,464)	0	0	(80,601)	0	0	0	0	0	0	0	(111,065)	16
	C. General Administration													
17	Administrative	(14,595)	0	(692,334)	0	856	(230,778)	0	0	0	0	0	(936,851)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,865)	0	86,618	849	(291,300)	0	0	0	0	0	0	(220,698)	19
20	Fees, Subscriptions & Promotions	(111,491)	0	596	770	670	0	0	0	0	0	0	(109,455)	20
21	Clerical & General Office Expenses	(17,584)	0	2,928	5,028	197,322	0	0	0	0	0	0	187,694	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	0	3,906	4,658	4,747	0	0	0	0	0	0	13,311	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,355	2,351	1,788	0	0	0	0	0	0	7,494	26
27	Other (specify):*	(179,700)	0	0	0	0	0	0	0	0	0	0	(179,700)	27
28	TOTAL General Administration	(340,235)	0	(594,931)	13,656	(85,917)	(230,778)	0	0	0	0	0	(1,238,205)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(372,588)	0	(594,931)	(66,945)	(85,917)	(230,778)	0	0	0	0	0	(1,351,159)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(11,335)	209,190	546	250	3,956	0	0	0	0	0	0	202,607	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(102)	277,704	0	0	0	0	0	0	0	0	0	277,602	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	0	2,067	41,970	0	0	0	0	0	0	(718,813)	34
35	Rent-Equipment & Vehicles	0	0	3,831	2,870	2,930	0	0	0	0	0	0	9,631	35
36	Other (specify):*	0	23,519	0	0	0	0	0	0	0	0	0	23,519	36
37	TOTAL Ownership	(11,437)	(252,437)	4,377	5,187	48,856	0	0	0	0	0	0	(205,454)	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)	(384,025)	(252,437)	(590,554)	(61,758)	(37,061)	(230,778)	0	0	0	0	0	(1,556,613)	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		COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

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	34 RENT	\$ 762,850	COUNTRYSIDE HEALTH CENTRE		\$	(762,850)	1
2	V	36 MORTGAGE INSURANCE		"		23,519	23,519	2
3	V	30 DEPRECIATION - BLDG/IMP		"		208,734	208,734	3
4	V	30 DEPRECIATION - EQPT/FURN		"		456	456	4
5	V	32 AMORTIZATION - MTG COST		"		1,283	1,283	5
6	V	32 INTEREST - MORTGAGE		"		254,127	254,127	6
7	V	32 INTEREST - OTHER		"		22,294	22,294	7
8	V			"				8
9	V			"				9
10	V			"				10
11	V							11
12	V							12
13	V							13
14	Total		\$ 762,850			\$ 510,413	\$ * (252,437)	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	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 86,618	\$ 86,618
16	V	20 DUES & SUBSCRIPTIONS		"		596	596
17	V	21 CLERICAL		"		2,928	2,928
18	V	24 TRAVEL		"		3,906	3,906
19	V	26 INSURANCE		"		3,355	3,355
20	V	35 RENT - EQPT & VEHICLE		"		3,831	3,831
21	V	17 ADMINISTRATIVE	692,334	"			(692,334)
22	V	30 DEPRECIATION		"		546	546
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 692,334			\$ 101,780	\$ * (590,554)

* 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	10 NURSING	\$ 119,393	CARLYLE NURSING ASSOCIATES, LLC		\$ 38,792	\$ (80,601)
16	V	19 PROFESSIONAL FEES		"		849	849
17	V	20 DUES & SUBSCRIPTIONS		"		770	770
18	V	21 CLERICAL		"		5,028	5,028
19	V	24 TRAVEL		"		4,658	4,658
20	V	26 INSURANCE		"		2,351	2,351
21	V	30 DEPRECIATION		"		250	250
22	V	34 RENT		"		2,067	2,067
23	V	35 RENT - EQPT & VEHICLE		"		2,870	2,870
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 119,393			\$ 57,635	\$ * (61,758)

* 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	19 PROFESSIONAL FEES	\$ 294,624	THE KENSINGTON GROUP, LLC		\$ 3,324	\$ (291,300)
16	V	20 DUES & SUBSCRIPTIONS		"		670	670
17	V	21 CLERICAL		"		197,322	197,322
18	V	24 TRAVEL		"		4,747	4,747
19	V	26 INSURANCE		"		1,788	1,788
20	V	30 DEPRECIATION		"		3,956	3,956
21	V	34 RENT		"		41,970	41,970
22	V	35 RENT - EQPT & VEHICLES		"		2,930	2,930
23	V	17 ADMINISTRATIVE		"		856	856
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 294,624			\$ 257,563	\$ * (37,061)

* 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	17 ADMINISTRATIVE	\$ 230,778	CHESTERFIELD		\$	\$ (230,778)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 230,778			\$ 0	\$ * (230,778)

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

Facility Name & ID Number

COUNTRYSIDE CARE CENTRE

#

0040931

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 WITTINGHAM MANAGEMENT ASSOC. LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	345,796	7	\$ 419,864	\$ 71,332	\$ 86,618	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	7	2,888	71,332	596	2
3	21	CLERICAL	PATIENT DAYS	345,796	7	14,195	71,332	2,928	3
4	24	TRAVEL	PATIENT DAYS	345,796	7	18,932	71,332	3,906	4
5	26	INSURANCE	PATIENT DAYS	345,796	7	16,262	71,332	3,355	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	345,796	7	18,569	71,332	3,831	6
7	17	ADMINISTRATIVE	PATIENT DAYS	345,796	7		71,332	0	7
8	30	DEPRECIATION	PATIENT DAYS	345,796	7	2,647	71,332	546	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 493,357	\$	\$ 101,780	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 CARLYLE NURSING ASSOC., LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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	DIRECT HOURS	1	\$ 38,792	\$ 38,792	1	\$ 38,792	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	71,332	849	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	71,332	770	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	71,332	5,028	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	71,332	4,658	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	71,332	2,351	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	71,332	250	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	71,332	2,067	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	522,604	11	21,023	71,332	2,870	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 176,839	\$ 38,792		\$ 57,635	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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 THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTONG GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	9	\$ 24,352	\$ 71,332	\$ 3,324	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	9	4,910	71,332	670	2
3	21	CLERICAL	PATIENT DAYS	522,604	9	162,920	71,332	22,237	3
4	24	TRAVEL	PATIENT DAYS	522,604	9	34,777	71,332	4,747	4
5	26	INSURANCE	PATIENT DAYS	522,604	9	13,097	71,332	1,788	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	9	28,982	71,332	3,956	6
7	34	RENT	PATIENT DAYS	522,604	9	307,494	71,332	41,970	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	522,604	9	21,468	71,332	2,930	8
9	17	ADMINISTRATIVE	DIRECT HOURS	1	1	856	1	856	9
10	21	CLERICAL	DIRECT HOURS	1	1	175,085	1	175,085	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 773,941	\$	\$ 257,563	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	GMAC		X	MORTGAGE	\$60,450.43	12/03	4,826,200	4,679,320	12/38	0.0540	254,127	2						
3	GMAC		X	LOAN COST	35 YR AMORT	12/03	52,135	40,985			1,283	3						
4												4						
5												5						
Working Capital																		
6	LOAN - PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	202,383	DEMAND	VARIES	15,974	6						
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	2,858,769	DEMAND	VARIES	211,176	7						
8	LETTER OF CREDIT FEES		X								1,379	8						
9	TOTAL Facility Related				\$60,450.43		\$ 5,485,924	\$ 7,781,457			\$ 483,939	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 5,485,924	\$ 7,781,457			\$ 483,939	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	131,544	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.)		\$	139,081	2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,537	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	140,616	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 \$ <u>344</u> For <u>2002</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.) & 2003		\$	(344)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	147,809	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	97,597	8
	2002	105,650	9
	2003	123,696	10
	2004	130,117	11
	2005	139,081	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 2005 TAX BILL.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>139,081.04</u>	\$ <u>139,081.04</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>139,081.04</u>	\$ <u>139,081.04</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CONST. 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: _____ 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>130,679</u>	<u>1981</u>	<u>\$ 98,000</u>	<u>1</u>
2	<u>854 BASIS ADJ</u>		<u>1982</u>	<u>16,345</u>	<u>2</u>
3	TOTALS	130,679		\$ 114,345	3

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207	1981		\$ 2,111,156	\$	30	\$ 70,372	\$ 70,372	\$ 1,781,266	4
5	754 BASIS ADJ		1992	403,542	12,811	31.5	12,811		185,760	5
6										6
7										7
8										8
	Improvement Type**									
9	*****RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE*****									
10	BUILDING IMPROVEMENTS		1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS		1983	26,282		15				11
12	VINYL TILING		1984	76,250		20			76,250	12
13	ROOF REPAIR		1985	6,644		20			6,644	13
14	VARIOUS IMPROVEMENTS		1986	1,609		15			1,609	14
15	VARIOUS IMPROVEMENTS		1987	36,433	1,157	31.5	1,157		34,864	15
16	BLACK TOP PAVING		1988	1,594		15			1,594	16
17	HOT WATER PIPING		1988	5,837	185	31.5	185		3,369	17
18	ROOFING IMPROVEMENTS		1989	51,879	1,647	31.5	1,647		29,166	18
19	SHOWER STALLS		1990	7,000	222	31.5	222		3,663	19
20	PAVING		1990	7,930		15			7,930	20
21	VARIOUS IMPROVEMENTS		1991	24,486	777	31.5	777		18,086	21
22	VARIOUS IMPROVEMENTS		1992	43,773	1,390	31.5	1,390		20,019	22
23	VARIOUS IMPROVEMENTS		1993	13,286	421	31.5	421		5,833	23
24	VARIOUS IMPROVEMENTS		1993	40,598	1,041	39	1,041		13,835	24
25	VARIOUS IMPROVEMENTS		1994	214,320	5,494	39	5,494		66,892	25
26	VARIOUS IMPROVEMENTS		1994	62,476	4,167	15	4,167		52,084	26
27	KITCHEN REMODEL/SIGNS		1995	32,836	842	39	842		10,036	27
28	ELECTRICAL & LIGHTING		1995	31,634	811	39	811		8,410	28
29	ROOFING/DOORS/DUCTWORK		1995	15,211	390	39	390		4,060	29
30	ROOF REPAIRS/FIRE DAMPERS		1996	4,300	110	39	110		1,197	30
31	BLACK TOP PAVING		1996	3,400	87	39	87		881	31
32	DUCTWORK		1996	8,584	220	39	220		2,209	32
33	REMOVE & REPLACE HVAC ROOF UNITS		1998	28,363	727	39	727		6,028	33
34	ROOF REPAIRS - PATCHING		1998	6,500	167	39	167		1,482	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST		1998	3,987	102	39	102		914	35
36	BOILER		1998	6,556	168	39	168		1,449	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	\$ 58,243	\$ 2,118	27.5	\$ 2,118	\$	\$ 16,856	37
38	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		7,876	38
39	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404	27.5	404		3,148	39
40	DINING RMS/WASHROOM - REMODEL/NEW ROOF	1999	165,984	6,035	27.5	6,035		46,521	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		10,805	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		7,180	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624	27.5	4,624		34,488	43
44	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	947	27.5	947		6,984	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661	27.5	30,661		221,019	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		18,335	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		1,322	47
48	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336	27.5	2,336		15,477	48
49	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		1,080	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		1,783	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		2,009	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		1,224	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		19,228	53
54	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		1,969	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		5,317	55
56	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		1,416	56
57	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		8,148	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		20,910	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		5,472	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		15,192	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		3,284	61
62	STIR FREE LINT FILTER	2000	1,399	51	27.5	51		317	62
63	NEW ROOF	2000	20,995	763	27.5	763		4,674	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		23,073	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		735	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	408	27.5	408		2,465	66
67	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		1,613	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		23,956	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	606	27.5	606		3,561	69
70	TOTAL (lines 4 thru 69)		\$ 5,426,228	\$ 110,024		\$ 180,396	\$ 70,372	\$ 2,949,325	70

**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:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12A, Carried Forward		\$ 5,426,228	\$ 110,024		\$ 180,396	\$ 70,372	\$ 2,949,325	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		705	2
3	INSTALL HYDRAULIC PUMPING UNIT - KITCHEN ELEVATOR	2001	7,495	273	27.5	273		1,581	3
4	REPLACE WATER CLOSETS 7 FLUSH VALVES - KITCHEN	2001	7,737	281	27.5	281		1,581	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		582	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		366	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	247	27.5	247		1,245	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		957	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HEATER	2002	14,988	545	27.5	545		2,702	9
10	SHWR RM REPAIRS, REMOVE OLD & FURNISH/INSTL. NEW	2002	26,388	959	27.5	959		4,756	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		356	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		311	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	55	27.5	55		222	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,835	15	5,835		26,465	14
15	F&I ONE INFRARED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		178	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		170	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		301	17
18	2-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		1,207	18
19	SUPPLY & INSTALL WIRING FOR NEW 208-VOLT FREEZER	2003	1,651	60	27.5	60		198	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602,611,614,705,702	2003	3,666	133	27.5	133		405	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	923	27.5	923		2,346	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	82	27.5	82		195	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	133	27.5	133		316	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PROJECT	2004	3,751	250	15	250		625	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,950	27.5	2,950		6,761	25
26	COMPRESSOR	2004	2,100	76	27.5	76		174	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		115	27
28	NEW AZT FLOOR TILES FOR RMS 806,812,303,512,313,314	2004	5,590	203	27.5	203		448	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	153	27.5	153		338	29
30	REPLACE FLOOR TILES & WALL TILES IN RMS 502, 505								30
31	506,511,512,514,805 & 807	2005	5,600	204	27.5	204		331	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS - 1ST FLR W. WNG	2005	28,000	1,018	27.5	1,018		1,654	33
34	TOTAL (lines 1 thru 33)		\$ 5,779,286	\$ 125,628		\$ 196,000	\$ 70,372	\$ 3,006,916	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:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12B, Carried Forward		\$ 5,779,286	\$ 125,628		\$ 196,000	\$ 70,372	\$ 3,006,916	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	161	27.5	161		262	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	1,656	27.5	1,656		2,553	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	3,837	27.5	3,837		5,916	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	453	27.5	453		699	5
6	REPLACE SIDE WALKS	2005	4,000	145	27.5	145		212	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	201	27.5	201		260	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	394	27.5	394		509	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	81	27.5	81		98	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	142	27.5	142		160	10
11	INSTALL 667 SQ YARDS OF NYLON CARPET	2005	38,420	1,397	27.5	1,397		1,572	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS								13
14	ELECTRICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	600	27.5	600		675	14
15	REPLACE ROOF TOP UNIT - 1ST LFOOR DINING RM.	2005	9,842	358	27.5	358		403	15
16	F&I ELEVATOR SYSTEM CONTROLLER & TAPE	2006	14,875	518	27.5	518		518	16
17	ELECTRICAL PANEL & VENTILATORS OUTLET	2006	15,755	549	27.5	549		549	17
18	110 YARDS OF INTERFACE CARPET TILES IN ACTIVITY	2006	5,612	1,122	5	1,122		1,122	18
19	INSTALL HOT WATER LINE - KITCHEN TO LAUNDRY RM	2006	1,560	50	27.5	50		50	19
20	REPLACE BAD IGNITION MODULE, FLAME SENSORS,								20
21	IGNITOR, GAS REGULATOR	2006	3,290	95	27.5	95		95	21
22	6 WOOD DOORS & 18 HINGE HARDWARE	2006	2,951	85	27.5	85		85	22
23	WALLCOVERING FOR 600, 700, 800 LOUNGES	2006	3,165	633	5	633		633	23
24	INSTALL ELECTRICAL WIRING FOR OFFICE A/C	2006	1,535	30	27.5	30		30	24
25	REPLACED WATER HEATER	2006	14,013	191	27.5	191		191	25
26	6 WOOD DOORS & 18 HINGE HARDWARE	2006	3,368	36	27.5	36		36	26
27									27
28			SL ADJ.	70,372			(70,372)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,104,646	\$ 208,734		\$ 208,734	\$ 0	\$ 3,023,544	34

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

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	\$ 1,037,033	\$ 82,512	\$ 89,786	\$ 7,274	3-15 YRS	\$ 510,873	71
72	Current Year Purchases	124,061	24,812	6,203	(18,609)	3-15 YRS	6,203	72
73	Fully Depreciated Assets	72,985			0		72,985	73
74	RELATED PARTIES		5,208	5,208	0			74
75	TOTALS	\$ 1,234,079	\$ 112,532	\$ 101,197	\$ (11,335)		\$ 590,061	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)	\$ 7,453,070	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 321,266	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,931	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,335)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,613,605	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 24,350 Description: SEE SCHEDULE ATTACHED

(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	<u>FACILITY USE</u>	<u>99 DODGE RAM PR 2W</u>	\$ <u>295.13</u>	\$ <u>2,943</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 295.13	\$ 2,943	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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>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 type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
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	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	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	\$		\$ 379,198	\$		\$ 379,198	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			91,273			91,273	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			445,293			445,293	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				242,324		242,324	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, I.V. TPY & Other (specify): MEDICAL SUPPLIES	39-2					210,160		210,160	13
14	TOTAL			\$		\$ 915,764	\$ 452,484		\$ 1,368,248	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 COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ (422,205)	\$ (223,760)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>387,028</u>)	2,742,170	2,742,170	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	1,883	1,883	5
6	Prepaid Insurance	64,660	141,105	6
7	Other Prepaid Expenses	36,780	36,780	7
8	Accounts Receivable (owners or related parties)	880	3,085	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		430,493	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,424,168	\$ 3,131,756	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,589,945	15
16	Equipment, at Historical Cost	1,234,079	1,234,079	16
17	Accumulated Depreciation (book methods)	(1,046,356)	(3,987,062)	17
18	Deferred Charges		40,985	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 187,723	\$ 3,087,103	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,611,891	\$ 6,218,859	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,682,576	\$ 1,682,576	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	194,370	194,370	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,538	221,538	30
31	Accrued Taxes Payable (excluding real estate taxes)	36,846	36,846	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,616	32
33	Accrued Interest Payable		21,057	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	281,457	281,457	36
37	<u>DUE TO LESSOR/PRIOR OWNER</u>	1,207,836	0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,624,623	\$ 2,578,460	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,705,111	3,061,152	39
40	Mortgage Payable		4,679,320	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)	\$ 2,705,111	\$ 7,740,472	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,329,734	\$ 10,318,932	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,717,843)	\$ (4,100,073)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,611,891	\$ 6,218,859	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,354,861)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ	5	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,354,856)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,362,987)	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)	\$ (1,362,987)	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)	\$ (3,717,843)	24 *

* This must agree with page 17, line 47.

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	\$ 11,411,186	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,411,186	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	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	210	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 102	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)	\$ 11,411,498	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,528,714	31
32	Health Care	5,124,171	32
33	General Administration	3,388,508	33
	B. Capital Expense		
34	Ownership	1,251,511	34
	C. Ancillary Expense		
35	Special Cost Centers	1,368,248	35
36	Provider Participation Fee	113,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,774,485	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,362,987)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,362,987)	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.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	1,942	2,158	\$ 79,399	\$ 36.79	1
2	Assistant Director of Nursing	3,788	4,310	131,040	30.40	2
3	Registered Nurses	42,868	46,237	1,276,972	27.62	3
4	Licensed Practical Nurses	31,689	33,589	899,801	26.79	4
5	CNAs & Orderlies	122,404	130,880	1,846,956	14.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,128	4,548	70,626	15.53	8
9	Activity Director	3,103	3,527	51,475	14.59	9
10	Activity Assistants	7,268	7,686	70,939	9.23	10
11	Social Service Workers	4,084	4,575	71,417	15.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,450	12,979	173,072	13.33	14
15	Cook Helpers/Assistants	19,984	20,809	171,672	8.25	15
16	Dishwashers					16
17	Maintenance Workers	2,029	2,375	50,183	21.13	17
18	Housekeepers	28,469	30,760	291,960	9.49	18
19	Laundry	4,198	5,674	56,899	10.03	19
20	Administrator	1,949	2,238	133,085	59.47	20
21	Assistant Administrator	1,930	2,151	51,179	23.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,927	12,004	212,843	17.73	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	6,196	6,877	151,950	22.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,406	333,377	\$ 5,791,468 *	\$ 17.37	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	250	\$ 15,583	1-3	35
36	Medical Director	132	15,000	9-3	36
37	Medical Records Consultant	32	1,504	10-3	37
38	Nurse Consultant	648	118,142	10-3	38
39	Pharmacist Consultant	96	2,400	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	25	1,415	11-3	44
45	Social Service Consultant	18	10,024	12-3	45
46	Other(specify) <u>UTILIZATION REV</u>	36	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,237	\$ 170,068		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	122	\$ 6,386	10-3	50
51	Licensed Practical Nurses	93	4,232	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	215	\$ 10,618		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
KIM KOHLS	ADMINISTRATOR		\$ 133,085	Workers' Compensation Insurance	\$ 128,886	IDPH License Fee	\$	
KATIE MCGOVERN	ASST ADMIN		51,179	Unemployment Compensation Insurance	96,230	Advertising: Employee Recruitment	9,785	
				FICA Taxes	438,090	Health Care Worker Background Check	2,700	
				Employee Health Insurance	309,844	(Indicate # of checks performed <u>270</u>)		
				Employee Meals	0	Patient Background Checks	338	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	5,786	
				EMPLOYEE BENEFITS - OTHER	14,107	MARKETING/ADV/PROMO	105,705	
				EMPLOYEE PHYSICAL EXAMS	280	LICENSES/DUES/SUBSCRIPTIONS	10,462	
				PENSION/PROFIT SHARING PLANS	6,815	MGMT CO ALLOC	2,036	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(5,786)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(86,837)	
						Yellow page advertising	(18,868)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 184,264	TOTAL (agree to Schedule V, line 22, col.8)	\$ 994,252	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,363	
(List each licensed administrator separately.)								
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
WITTINGHAM MANAGEMENT ASSOC. LLC			\$ 692,334			\$	Out-of-State Travel	\$
CHESTERFIELD, LLC			230,778					
							In-State Travel	
							TRAVEL	595
							RELATED PARTY	13,311
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 923,112	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 13,906
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			408,705					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 408,705					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2005	\$ 4,033	3	\$	\$	\$ 672	\$ 1,344	\$ 1,344	\$ 673	\$	\$	\$							
2	PAINT/DECORATING	2006	1,961	3				326	654	654	327									
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 5,994		\$	\$	\$ 672	\$ 1,670	\$ 1,998	\$ 1,327	\$ 327	\$	\$							

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

0040931

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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. ILL COUNCIL ON LTC - \$11537
- (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. \$ 5,540 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 during this cost report period. \$ 113,333
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? 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. \$ N/A
- (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