



Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	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			2,656	2,656	8
9	SNF/PED					9
10	ICF	58,527	297		58,824	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,527	297	2,656	61,480	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.50%

D. How many bed-hold days during this year were paid by the Department? 993 (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 11/1/90

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/1/90 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 2,291

Medicare Intermediary ADMINISTAR

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 HEALTHCARE CENTER** # **0036632** 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
	<b>A. General Services</b>										
1	Dietary	174,521	26,066	14,065	214,652		214,652	0	214,652		1
2	Food Purchase		258,014		258,014	0	258,014	(798)	257,216		2
3	Housekeeping	143,439	44,653	0	188,092		188,092	0	188,092		3
4	Laundry	68,097	10,430	0	78,527	0	78,527	0	78,527		4
5	Heat and Other Utilities			135,174	135,174		135,174	45	135,219		5
6	Maintenance	85,143	29,023	29,893	144,059		144,059	7,439	151,498		6
7	Other (specify):*			11,370	11,370		11,370	22	11,392		7
8	<b>TOTAL General Services</b>	<b>471,200</b>	<b>368,186</b>	<b>190,502</b>	<b>1,029,888</b>	<b>0</b>	<b>1,029,888</b>	<b>6,708</b>	<b>1,036,596</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		8,500	8,500		8,500	0	8,500		9
10	Nursing and Medical Records	1,533,423	71,922	87,520	1,692,865		1,692,865	(22,643)	1,670,222		10
10a	Therapy	46,790	6,793	59,836	113,419		113,419	(3,515)	109,904		10a
11	Activities	93,132	20,913	800	114,845		114,845	0	114,845		11
12	Social Services	326,855		0	326,855		326,855	0	326,855		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			60	60		60	0	60		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,000,200</b>	<b>99,628</b>	<b>156,716</b>	<b>2,256,544</b>	<b>0</b>	<b>2,256,544</b>	<b>(26,158)</b>	<b>2,230,386</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	117,518		444,000	561,518		561,518	(320,097)	241,421		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			262,690	262,690		262,690	(196,279)	66,411		19
20	Dues, Fees, Subscriptions & Promotions			26,055	26,055		26,055	416	26,471		20
21	Clerical & General Office Expenses	110,576	21,323	262,737	394,636		394,636	(144,815)	249,821		21
22	Employee Benefits & Payroll Taxes			378,106	378,106	0	378,106	0	378,106		22
23	Inservice Training & Education			0	0		0	2,455	2,455		23
24	Travel and Seminar			3,934	3,934		3,934	1,313	5,247		24
25	Other Admin. Staff Transportation			10,192	10,192		10,192	3,618	13,810		25
26	Insurance-Prop.Liab.Malpractice			246,118	246,118		246,118	1,751	247,869		26
27	Other (specify):*			0	0		0	69,396	69,396		27
28	<b>TOTAL General Administration</b>	<b>228,094</b>	<b>21,323</b>	<b>1,633,832</b>	<b>1,883,249</b>	<b>0</b>	<b>1,883,249</b>	<b>(582,242)</b>	<b>1,301,007</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,699,494</b>	<b>489,137</b>	<b>1,981,050</b>	<b>5,169,681</b>	<b>0</b>	<b>5,169,681</b>	<b>(601,692)</b>	<b>4,567,989</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	12,947
	REPAIRS & MAINTENANCE	1,118
		0
		14,065
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	38,199
	ELECTRICITY	66,496
	WATER	28,914
	CABLE TV - LOBBY	1,565
		135,174
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,839
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	15,197
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,795
	FIRE SERVICE	5,062
		0
		0
		0
		0
		29,893
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	11,314
	SECURITY SERVICE	56
		0
		0
		11,370
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,500
		8,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	26
	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	3,540
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	1,000
	DENTAL SERVICES	3,900
	PROGRAM CONSULTANT	77,550
		87,520
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	1,877
	SPEECH THERAPY SERVICES	1,620
	OCCUPATIONAL THERAPY SERVICES	8,681
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	7,200
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	7,200
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	33,258
		59,836
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	800
		0
		800
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	60
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	444,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	29,001
	ADMINISTRATIVE CONSULTANTS XIX C	186,000
	PROFESSIONAL FEES XIX C	47,689
		0
		262,690
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,789
	EMPLOYEE WANT ADS XIX F	20,246
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	2,813
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	493
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	300
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	186
	PATIENT BACKGROUND CHECKS XIX F	228
		26,055
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	860
	EQUIPMENT REPAIR & MAINTENANCE	6,756
	OUTSIDE CLERICAL SERVICES	182,964
	PENALTIES / OVERDRAFT CHARGES VI 18	48,239
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	22,965
	MESSENGER SERVICE	953
		0
		262,737

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	207,015
	UNEMPLOYMENT COMPENSATION XIX D	82,698
	WORKERS COMPENSATION INSURANC XIX D	65,058
	HOSPITALIZATION INSURANCE XIX D	15,662
	EMPLOYEE BENEFITS - OTHER XIX D	6,332
	EMPLOYEE PHYSICAL EXAMS XIX D	55
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,286
	CHICAGO HEAD TAX XIX D	0
		0
		378,106
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	3,615
	TRAVEL XIX G	319
		3,934
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	10,192
		10,192
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	246,118
		246,118
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,981,050

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

TOTAL FOOD PURCHASE	258,014	PATIENT MEALS	184440
LESS SALES TAX	(798)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	257,216	TOTAL MEALS/YEAR	184440
TOTAL PATIENT CENSUS	61,480	NET FOOD	257216
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	184440
	-----		
TOTAL PATIENT MEALS	184440	COST PER MEAL	1.39
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

COUNTRYSIDE HEALTHCARE CENTER

#0036632

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			47,326	47,326		47,326	165,503	212,829			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			9,266	9,266		9,266	540,833	550,099			32
33	Real Estate Taxes			512,292	512,292		512,292	5,537	517,829			33
34	Rent-Facility & Grounds			693,935	693,935		693,935	(693,935)	0			34
35	Rent-Equipment & Vehicles			59,436	59,436		59,436	(19,585)	39,851			35
36	Other (specify):*				0		0	0	0			36
37	<b>TOTAL Ownership</b>			1,322,255	1,322,255	0	1,322,255	(1,647)	1,320,608			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		55,444	66,292	121,736		121,736	(8,007)	113,729			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			107,858	107,858		107,858	0	107,858			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	55,444	174,150	229,594	0	229,594	(8,007)	221,587			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,699,494	544,581	3,477,455	6,721,530	0	6,721,530	(611,346)	6,110,184			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	75	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(798)	2		13
14	Non-Care Related Interest	(30,970)	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	(48,239)	21		18
19	Entertainment	0	20		19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(1,789)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(493)	20		28
29	Other-Attach Schedule	0			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (82,514)</b>		<b>\$ 0</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(528,832)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (528,832)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (611,346)</b>		<b>37</b>

**\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

ID# 0036632

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(798)	0	0	0	0	0	0	0	0	0	0	(798)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	45	0	0	0	0	0	0	0	0	45	5
6	Maintenance	0	0	7,439	0	0	0	0	0	0	0	0	7,439	6
7	Other (specify):*	0	0	22	0	0	0	0	0	0	0	0	22	7
8	<b>TOTAL General Services</b>	<b>(798)</b>	<b>0</b>	<b>7,506</b>	<b>0</b>	<b>6,708</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(22,643)	0	0	0	0	0	0	0	0	(22,643)	10
10a	Therapy	0	(7,227)	3,712	0	0	0	0	0	0	0	0	(3,515)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(7,227)</b>	<b>(18,931)</b>	<b>0</b>	<b>(26,158)</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	(320,097)	0	0	0	0	0	0	0	0	(320,097)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(196,279)	0	0	0	0	0	0	0	0	(196,279)	19
20	Fees, Subscriptions & Promotions	(2,582)	0	2,998	0	0	0	0	0	0	0	0	416	20
21	Clerical & General Office Expenses	(48,239)	0	(96,576)	0	0	0	0	0	0	0	0	(144,815)	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	2,455	0	0	0	0	0	0	0	0	2,455	23
24	Travel and Seminar	0	0	1,313	0	0	0	0	0	0	0	0	1,313	24
25	Other Admin. Staff Transportation	0	0	3,618	0	0	0	0	0	0	0	0	3,618	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,751	0	0	0	0	0	0	0	0	1,751	26
27	Other (specify):*	0	0	69,396	0	0	0	0	0	0	0	0	69,396	27
28	<b>TOTAL General Administration</b>	<b>(50,821)</b>	<b>0</b>	<b>(531,421)</b>	<b>0</b>	<b>(582,242)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(51,619)</b>	<b>(7,227)</b>	<b>(542,846)</b>	<b>0</b>	<b>(601,692)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	75	151,669	0	13,759	0	0	0	0	0	0	0	165,503	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,970)	531,815	0	39,988	0	0	0	0	0	0	0	540,833	32
33	Real Estate Taxes	0	0	0	5,537	0	0	0	0	0	0	0	5,537	33
34	Rent-Facility & Grounds	0	(693,935)	0	0	0	0	0	0	0	0	0	(693,935)	34
35	Rent-Equipment & Vehicles	0	(29,856)	0	10,271	0	0	0	0	0	0	0	(19,585)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(30,895)</b>	<b>(40,307)</b>	<b>0</b>	<b>69,555</b>	<b>0</b>	<b>(1,647)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(8,007)	0	0	0	0	0	0	0	0	0	(8,007)	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>(8,007)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,007)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(82,514)</b>	<b>(55,541)</b>	<b>(542,846)</b>	<b>69,555</b>	<b>0</b>	<b>(611,346)</b>	<b>45</b>						

**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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				COUNTRYSIDE		
				H/C LLC	SKOKIE	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	34 RENT	\$ 693,935	COUNTRYSIDE HEALTHCARE CENTER, LLC		\$	(693,935)	1
2	V	30 SL DEPRECIATION		" "		147,798	147,798	2
3	V	32 INTEREST		" "		529,432	529,432	3
4	V							4
5	V							5
6	V							6
7	V	10A THERAPY SERVICES	59,834	CAREPLUS REHABILITATIVE SERVICES		52,607	(7,227)	7
8	V	39 ANCILLARY THERAPY	66,290	" "		58,283	(8,007)	8
9	V	35 EQUIPMENT RENT	29,856	" "			(29,856)	9
10	V	30 SL DEPRESIATION		" "		3,871	3,871	10
11	V	32 INTEREST		" "		2,383	2,383	11
12	V							12
13	V							13
14	Total		\$ 849,915			\$ 794,374	\$ * (55,541)	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	10 PROGRAM CONS. FEES	\$ 77,550	CAREPLUS MGMT. INC.		\$	\$ (77,550) 15
16	V	17 MANAGEMENT FEES	444,000	" "			(444,000) 16
17	V	19 ADMIN. CONSULT. FEES	186,000	" "			(186,000) 17
18	V	19 DATA PROCESS FEES	14,400	" "			(14,400) 18
19	V	21 CLERICAL FEES	181,411	" "			(181,411) 19
20	V	27 W/C INSURANCE	12,699	" "			(12,699) 20
21	V						
22	V						
23	V	5 UTILITIES		" "		45	45 23
24	V	6 MAINT AND REPAIR		" "		1,858	1,858 24
25	V	6 MAINTENANCE SALARIES		" "		5,581	5,581 25
26	V	7 SECURITY		" "		22	22 26
27	V	10 NURSING SALARIES		" "		54,907	54,907 27
28	V	10A THERAPY SALARIES		" "		3,712	3,712 28
29	V	17 ADMIN. SALARIES		" "		123,903	123,903 29
30	V	19 PROFESSIONAL FEES		" "		4,121	4,121 30
31	V	20 ADVERTISING		" "		2,998	2,998 31
32	V	21 TOTAL OFFICE		" "		18,283	18,283 32
33	V	21 CLERICAL SALARIES		" "		66,552	66,552 33
34	V	23 SEMINARS		" "		2,455	2,455 34
35	V	24 TRAVEL		" "		1,313	1,313 35
36	V	25 TRANSPORTATION		" "		3,618	3,618 36
37	V	26 INSURANCE		" "		1,751	1,751 37
38	V	27 EMPLOYEE BENEFITS		" "		82,095	82,095 38
39	Total		\$ 916,060			\$ 373,214	\$ * (542,846) 39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 DEPRECIATION (SL)	\$	CAREPLUS MGMT. INC.		\$ 13,759	\$	13,759	15
16	V	33 REAL ESTATE TAX		" "		5,537		5,537	16
17	V	32 INTEREST		" "		35,014		35,014	17
18	V	32 INTEREST-TAG 18 PPTY-MTG		" "		4,645		4,645	18
19	V	32 INTEREST-CP REHAB-EQ LOAN		" "		329		329	19
20	V	35 EQUIPMENT RENT		" "		10,271		10,271	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 69,555	\$ *	69,555	39

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

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 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	<b>CAREPLUS MGMT ALLOCATIONS:</b>								\$		1
2	SHERWIN RAY	PRESIDENT	ADMINISTRATIVE	36.17	SEE ATTACHED	6.7		SALARY	22,227	17-7	2
3			FINANCE		SCHEDULE						3
4	JACOB BAKST	DIR OPERATIONS	ADMINISTRATIVE	21.57		6.7		SALARY	22,227	17-7	4
5			CONSULTING								5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		6.7		SALARY	5,476	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 49,930		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 HEALTHCARE CENTER

# 0036632

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 CAREPLUS MANAGEMENT, INC.  
 Street Address 8320 SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL 60077  
 Phone Number ( 847 ) 329-1555  
 Fax Number ( 847 ) 329-9555

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	5	UTILITIES	CENSUS DAYS	553,205	13	\$ 408	\$ 61,480	\$ 45	1
2	6	MAINT & REPAIRS	CENSUS DAYS	553,205	13	16,722	61,480	1,858	2
3	6	MAINTENANCE SALARIES	CENSUS DAYS	553,205	13	50,215	61,480	5,581	3
4	7	SECURITY	CENSUS DAYS	553,205	13	194	61,480	22	4
5	10	NURSING SALARIES	CENSUS DAYS	553,205	13	494,063	61,480	54,907	5
6	10A	THERAPY SALARIES	CENSUS DAYS	553,205	13	33,400	61,480	3,712	6
7	17	ADMIN SALARIES	CENSUS DAYS	553,205	13	1,114,897	61,480	123,903	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	553,205	13	37,085	61,480	4,121	8
9	20	ADVERTISING	CENSUS DAYS	553,205	13	26,974	61,480	2,998	9
10	21	TOTAL OFFICE	CENSUS DAYS	553,205	13	164,515	61,480	18,283	10
11	21	CLERICAL SALARIES	CENSUS DAYS	553,205	13	598,842	61,480	66,552	11
12	23	SEMINAR	CENSUS DAYS	553,205	13	22,090	61,480	2,455	12
13	24	TRAVEL	CENSUS DAYS	553,205	13	11,815	61,480	1,313	13
14	25	TRANSPORTATION	CENSUS DAYS	553,205	13	32,553	61,480	3,618	14
15	26	INSURANCE	CENSUS DAYS	553,205	13	15,760	61,480	1,751	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,205	13	738,700	61,480	82,095	16
17	30	DEPRECIATION ( SL )	CENSUS DAYS	553,205	13	123,804	61,480	13,759	17
18	33	REAL ESTATE TAX	CENSUS DAYS	553,205	13	49,822	61,480	5,537	18
19	32	INTEREST	CENSUS DAYS	553,205	13	315,063	61,480	35,014	19
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	553,205	13	41,794	61,480	4,645	20
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	553,205	13	2,962	61,480	329	21
22	35	EQUIPMENT RENT	CENSUS DAYS	553,205	13	92,424	61,480	10,271	22
23									23
24									24
25	TOTALS				\$ 3,984,102	\$ 2,291,417		\$ 442,769	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

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	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	*LAKE FOREST BANK		X	MORTGAGE	\$55,766.87	02/06	\$ 8,000,000	\$ 7,886,079	02/36	RIME+	\$ 453,524	1								
2	*LOAN FEES		X	LOAN FEES	W/O OVER LOAN		102,695	99,700			2,995	2								
3	*COUNTRYSIDE PLAZA		X	JR MORTGAGE		05/98	1,978,877	0	05/08	0.0950	31,604	3								
4	*CIB BANK		X	CAPITAL IMPROVEMENTS		01/04	540,000	77,219	01/09	PRIME+	7,941	4								
5	*CORUS BANK		X	MORTGAGE		05/98	4,343,980	0		0.0939	33,368	5								
<b>Working Capital</b>																				
6	CAREPLUS MANAGEMENT ALLOCATION										39,988	6								
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING							9,266	7								
8	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS										2,383	8								
9	TOTAL Facility Related				\$55,766.87		\$ 14,965,552	\$ 8,062,998			\$ 581,069	9								
<b>B. Non-Facility Related*</b>																				
10	**RELATED PARTY: COUNTRYSIDE HEALTHCARE CENTER,LLC											10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14								
15	TOTALS (line 9+line14)						\$ 14,965,552	\$ 8,062,998			\$ 581,069	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.		\$	<b>483,370</b>	<b>1</b>
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.)		\$	<b>495,354</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>11,984</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>500,308</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>512,292</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>458,382</b>	<b>8</b>
	<b>2002</b>	<b>434,119</b>	<b>9</b>
	<b>2003</b>	<b>444,090</b>	<b>10</b>
	<b>2004</b>	<b>478,584</b>	<b>11</b>
	<b>2005</b>	<b>495,354</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**



Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,547 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>132,928</u>	<u>1998</u>	<u>\$ 392,750</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>132,928</b>		<b>\$ 392,750</b>	<b>3</b>

Facility Name &amp; ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

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	1997			\$ 5,408,525	\$ 138,675	39	\$ 138,675	\$	\$ 1,196,207	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1991	24,648	782	31.5	782		12,399	9
10	LEASEHOLD IMPROVEMENTS		1992	28,172	894	31.5	894		13,009	10
11	LEASEHOLD IMPROVEMENTS		1993	11,940	337	31.5	337		4,906	11
12	LEASEHOLD IMPROVEMENTS		1994	4,878	125	39	125		1,544	12
13	TILE / ROOF VENTS		1995	16,191	416	39	416		4,789	13
14	WALL / WATER PANEL		1995	4,199	107	39	107		1,215	14
15	LANDSCAPING/PARKING LOT REPAIRS		1995	13,614	908	15	908		10,441	15
16	ROOF REPAIRS		1996	13,369	342	39	342		3,641	16
17	SINK		1996	683	18	39	18		189	17
18	ROOF-TOP A/C UNIT		1996	5,100	131	39	131		1,337	18
19	WINDOWS		1996	1,080	28	39	28		283	19
20	WINDOWS		1997	14,040	360	39	360		3,433	20
21	WALK-IN FREEZER		1997	3,196	82	39	82		769	21
22	WINDOWS		1998	8,370	214	39	214		1,860	22
23	FLOORING / TILE / CARPETING		1998	3,396	87	39	87		753	23
24	CEILING TILES		1998	2,213	57	39	57		468	24
25	ROOF REPAIRS / ROOFTOP A/C		1999	33,838	868	39	868		6,401	25
26	ROOF REPAIRS		2000	13,505	346	39	346		2,379	26
27	INSTALLATION CORNICES & SHEERS		2000	3,280	119	27.5	119		779	27
28	DRAPERY PANELS		2000	2,170	189	20	109	(80)	763	28
29	CARPETING OFFICES		2001	1,814	104	20	91	(13)	546	29
30	INSTALLED ROOF TOP UNIT		2001	6,992	254	27.5	254		1,281	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING,CEILING		2003	100,619	3,659	27.5	3,659		13,569	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS		2003	4,501	519	20	225	(294)	900	32
33	REPLACE FIRE ALARM SYSTEM		2003	5,204	189	27.5	189		622	33
34	NEW DURO-LAST ROOFING SYSTEM		2003	28,100	1,022	27.5	1,022		3,109	34
35	PAINTING		2004	4,100	787	20	205	(582)	615	35
36	BATHROOMS AND OFFICE REMODELING		2004	43,350	1,576	27.5	1,576		3,218	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 &amp; ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

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	REPLACED FRONT DOOR	2004	\$ 2,164	\$ 79	27.5	\$ 79		\$ 214	37
38	REPLACEMENT OF DECK PANELS	2005	74,108	2,695	27.5	2,695		5,278	38
39	INSTALLED DELAYED EGRESS	2005	6,875	250	27.5	250		469	39
40	VARIOUS WALKS	2006	5,000	56	15	333	277	333	40
41	INSTALLED EXHAUST FAN & SMOKE DAMPERS	2006	12,132	202	27.5	202		202	41
42	TUCKPOINTING	2006	4,850	81	27.5	81		81	42
43	FLOORING RESIDENT & BATHROOMS	2006	43,156	719	27.5	719		719	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	RELATED PARTY ALLOCATION:								54
55	COUNTRYSIDE HEALTHCARE CENTER LLC								55
56	ROOF	2001	255,225	9,123	39	9,123			56
57									57
58	CAREPLUS MGMT								58
59	BUILDING-TAG-18 PROPERTIES	2004	69,195	1784	39	1,784			59
60	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	27,184	1056	39	1,056			60
61									61
62	CAREPLUS REHAB								62
63	ROOF VENTILATOR	2003	1,967	50	39	50			63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,312,943	\$ 169,290		\$ 168,598	\$ (692)	\$ 1,298,721	70

\*\*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	\$ 290,425	\$ 20,393	\$ 26,123	\$ 5,730		\$ 175,468	71
72	Current Year Purchases	26,854	5,371	1,342	(4,029)		1,342	72
73	Fully Depreciated Assets	74,832			0		74,832	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		14,740	14,740	0			74
75	<b>TOTALS</b>	\$ 392,111	\$ 40,504	\$ 42,205	\$ 1,701		\$ 251,642	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		DODGE RAM BR 150	2006	\$ 10,132	\$ 2,960	\$ 2,026	\$ (934)	5	\$ 2,026	76
77							0			77
78							0			78
79							0			79
80	<b>TOTALS</b>			\$ 10,132	\$ 2,960	\$ 2,026	\$ (934)		\$ 2,026	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)	\$ 7,107,936	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 212,754	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 212,829	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 75	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,552,389	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	<b>TOTALS</b>	\$	\$	\$	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: \$ 47,393 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>CAREPLUS MGMT</u>		\$ <u>SEE ATTACHED</u>	\$ <u>4,919</u>	17
18					18
19	<u>FACILITY</u>	<u>2006 CHEVY EXPRESS</u>		<u>7,124</u>	19
20					20
21	TOTAL		\$ _____	\$ <u>12,043</u>	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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 47,476	\$		\$ 47,476	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			487			487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			18,329			18,329	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				55,289		55,289	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>LABORATORY</b>	39-2					155		155	13
14	<b>TOTAL</b>			\$		\$ 66,292	\$ 55,444		\$ 121,736	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 HEALTHCARE CENTER

# 0036632

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 35,019	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,635 )	3,179,939		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,409		6
7	Other Prepaid Expenses	218,478		7
8	Accounts Receivable (owners or related parties)	890,175		8
9	Other(specify): Real Estate Tax Escrow	158,031		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,623,051	\$ 0	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	550,846		15
16	Equipment, at Historical Cost	402,243		16
17	Accumulated Depreciation (book methods)	(461,599)		17
18	Deferred Charges			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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 491,490	\$ 0	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,114,541	\$ 0	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 987,384	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,065		28
29	Short-Term Notes Payable	1,380,926		29
30	Accrued Salaries Payable	163,243		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,017		31
32	Accrued Real Estate Taxes(Sch.IX-B)	500,308		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,097,943	\$ 0	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 0	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,097,943	\$ 0	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,016,598	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,114,541	\$ 0	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,422,460</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>POST CLOSING ADJ</b>	<b>48,671</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,471,131</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>545,467</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>545,467</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,016,598</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,236,027	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,236,027	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 0	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	30,970	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30,970	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 0	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,266,997	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,029,888	31
32	Health Care	2,256,544	32
33	General Administration	1,883,249	33
	<b>B. Capital Expense</b>		
34	Ownership	1,322,255	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	121,736	35
36	Provider Participation Fee	107,858	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,721,530	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	545,467	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 545,467	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 HEALTHCARE CENTER

# 0036632

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	1,845	1,923	\$ 65,311	\$ 33.96	1
2	Assistant Director of Nursing	2,851	3,168	96,548	30.48	2
3	Registered Nurses	7,830	7,954	203,632	25.60	3
4	Licensed Practical Nurses	26,677	27,449	609,578	22.21	4
5	CNAs & Orderlies	58,632	63,684	540,344	8.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,218	4,670	46,790	10.02	8
9	Activity Director	1,940	1,998	27,431	13.73	9
10	Activity Assistants	8,645	9,229	65,701	7.12	10
11	Social Service Workers	18,820	20,071	326,855	16.28	11
12	Dietician					12
13	Food Service Supervisor	2,023	2,119	34,202	16.14	13
14	Head Cook	4,654	5,243	48,186	9.19	14
15	Cook Helpers/Assistants	12,464	13,212	92,133	6.97	15
16	Dishwashers					16
17	Maintenance Workers	7,849	8,247	85,143	10.32	17
18	Housekeepers	18,952	20,103	143,439	7.14	18
19	Laundry	9,285	9,781	68,097	6.96	19
20	Administrator	2,066	2,193	77,912	35.53	20
21	Assistant Administrator	1,958	2,128	39,606	18.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,391	7,318	110,576	15.11	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	2,369	2,459	18,010	7.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,469	212,949	\$ 2,699,494 *	\$ 12.68	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	M	\$ 12,947	1-3	35
36	Medical Director	O	8,500	9-3	36
37	Medical Records Consultant	N	1,504	10-3	37
38	Nurse Consultant	T	1,000	10-3	38
39	Pharmacist Consultant	H	3,540	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	800	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) <u>Program Consultant</u>	S	77,550	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 120,241		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		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	
CALLIE GRAHAM	ADMINISTRATOR	0.00%	\$ 77,912	Workers' Compensation Insurance	\$ 65,058	IDPH License Fee	\$	
WILLIE WILSON	ASST ADMIN	0.00%	37,058	Unemployment Compensation Insurance	82,698	Advertising: Employee Recruitment	20,246	
ELI RAY	ASST ADMIN	0.00%	2,548	FICA Taxes	207,015	Health Care Worker Background Check	186	
				Employee Health Insurance	15,662	(Indicate # of checks performed <u>18</u> )		
				Employee Meals	0	Patient Background Checks	22	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	300	
				EMPLOYEE BENEFITS - OTHER	6,332	MARKETING/ADV/PROMO	2,282	
				EMPLOYEE PHYSICAL EXAMS	55	LICENSES/DUES/SUBSCRIPTIONS	2,813	
				PENSION/PROFIT SHARING PLANS	1,286	MGMT CO ALLOC	2,998	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(300)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(1,789)	
						Yellow page advertising	(493)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 117,518	TOTAL (agree to Schedule V, line 22, col.8)	\$ 378,106	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,471	
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
CAREPLUS MGMT MANAGEMENT FEES			\$ 444,000			\$	Out-of-State Travel	\$
							In-State Travel	
								319
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 444,000				MGMT CO ALLOC	1,313
C. Professional Services								
Vendor/Payee	Type		Amount					
CAREPLUS MANAGEMENT	DATA PROCESSING		\$ 14,400					
AMERICAN DATA	DATA PROCESSING		3,458					
NATIONAL DATA	DATA PROCESSING		2,065					
ACHIEVE HEALTHCARE	DATA PROCESSING		3,659					
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		5,419					
CAREPLUS MANAGEMENT	ADMIN. CONSULTANT		186,000					
KRUPNICK,BOKOR,KAGDA,LTD	ACCOUNTING FEES		25,800					
MEYER MAGENCE	LEGAL FEES		10,121					
ECONOCARE	PURCHASE CONSULTANT		2,364					
PERSONNEL PLANNER	UC CONSULTANT		1,104					
RICHARD PEELO	MEDICARE CONSULTANT		4,800					
FIRST REAL ESTATE SERVICES	REAL ESTATE APPRAISAL		3,500					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 262,690	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 5,247

\* Attach copy of IMRF notifications

\*\*See instructions.



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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (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. \$ 52 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. \$ 107,858  
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