

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

0036632 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			1,949	1,949	8
9	SNF/PED					9
10	ICF	62,418	348		62,766	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,418	348	1,949	64,715	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.00%

D. How many bed-hold days during this year were paid by the Department?
2,124 (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 1,628

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **COUNTRYSIDE HEALTHCARE CENTER** # **0036632** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	186,864	21,651	10,481	218,996		218,996		218,996		1
2	Food Purchase		284,050		284,050		284,050	(1,029)	283,021		2
3	Housekeeping	172,897	40,958		213,855		213,855		213,855		3
4	Laundry	62,725	11,720		74,445		74,445		74,445		4
5	Heat and Other Utilities			161,851	161,851		161,851	15	161,866		5
6	Maintenance	88,393	37,866	30,865	157,124		157,124	9,469	166,593		6
7	Other (specify):*			20,733	20,733		20,733	80	20,813		7
8	TOTAL General Services	510,879	396,245	223,930	1,131,054		1,131,054	8,535	1,139,589		8
	B. Health Care and Programs										
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	1,841,708	72,613	4,668	1,918,989		1,918,989	59,026	1,978,015		10
10a	Therapy	85,709	3,871	55,270	144,850		144,850	12,569	157,419		10a
11	Activities	95,857	20,994	709	117,560		117,560		117,560		11
12	Social Services	39,074			39,074		39,074		39,074		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,062,348	97,478	80,147	2,239,973		2,239,973	71,595	2,311,568		16
	C. General Administration										
17	Administrative	135,802		516,000	651,802		651,802	(391,555)	260,247		17
18	Directors Fees										18
19	Professional Services			371,733	371,733		371,733	(308,551)	63,182		19
20	Dues, Fees, Subscriptions & Promotions			22,094	22,094		22,094	(8,107)	13,987		20
21	Clerical & General Office Expenses	56,071	14,819	234,616	305,506		305,506	(87,527)	217,979		21
22	Employee Benefits & Payroll Taxes			348,594	348,594		348,594		348,594		22
23	Inservice Training & Education							2,040	2,040		23
24	Travel and Seminar			1,945	1,945		1,945	3,018	4,963		24
25	Other Admin. Staff Transportation			3,798	3,798		3,798	11,785	15,583		25
26	Insurance-Prop.Liab.Malpractice			314,200	314,200		314,200	2,542	316,742		26
27	Other (specify):*							84,129	84,129		27
28	TOTAL General Administration	191,873	14,819	1,812,980	2,019,672		2,019,672	(692,226)	1,327,446		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,765,100	508,542	2,117,057	5,390,699		5,390,699	(612,096)	4,778,603		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	9,606
	REPAIRS & MAINTENANCE	875
		0
		10,481
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	41,350
	ELECTRICITY	91,005
	WATER	28,695
	CABLE TV - LOBBY	801
		0
		161,851
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,488
	PAINTING & DECORATING	742
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	17,679
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,140
	FIRE SERVICE	3,816
		0
		0
		0
		0
		30,865
7	OTHER	
	SCAVENGER	20,682
	SECURITY SERVICE	51
		0
		0
		20,733
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	19,500
		19,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	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	1,128
	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	0
		0
		0
		4,668
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	959
	SPEECH THERAPY SERVICES	216
	OCCUPATIONAL THERAPY SERVICES	1,283
	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
	DENTAL SERVICES	4,400
	THERAPY CONTRACT SERVICES	34,012
		55,270
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	709
		0
		709
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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	516,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	51,115
	ADMINISTRATIVE CONSULTANTS XIX C	282,000
	PROFESSIONAL FEES XIX C	38,618
		0
		371,733
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,174
	EMPLOYEE WANT ADS XIX F	7,482
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	267
	LICENSES & PERMITS XIX F	2,159
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	12
	PATIENT BACKGROUND CHECKS XIX F	0
		22,094
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,163
	EQUIPMENT REPAIR & MAINTENANCE	2,721
	OUTSIDE CLERICAL SERVICES	157,209
	PENALTIES / OVERDRAFT CHARGES VI 18	53,217
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,569
	MESSENGER SERVICE	1,737
		0
		234,616

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	208,429
	UNEMPLOYMENT COMPENSATION XIX D	63,946
	WORKERS COMPENSATION INSURANC XIX D	53,421
	HOSPITALIZATION INSURANCE XIX D	12,766
	EMPLOYEE BENEFITS - OTHER XIX D	6,106
	EMPLOYEE PHYSICAL EXAMS XIX D	521
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	3,405
	CHICAGO HEAD TAX XIX D	0
		0
		348,594
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,945
	TRAVEL XIX G	0
		1,945
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,798
		3,798
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	314,200
		314,200
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

2,117,057

**COUNTRYSIDE HEALTHCARE CENTER
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	284,050
LESS SALES TAX	<u>(1,029)</u>
NET FOOD	283,021

TOTAL PATIENT CENSUS	64,715
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	194,145

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	194,145
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	194,145

NET FOOD	283,021
DIVIDE TOTAL MEALS/YEAR	<u>194,145</u>

COST PER MEAL	1.46
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

COUNTRYSIDE HEALTHCARE CENTER

#0036632

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,891	45,891		45,891	175,745	221,636			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,349	4,349		4,349	538,492	542,841			32
33	Real Estate Taxes			464,510	464,510		464,510	8,159	472,669			33
34	Rent-Facility & Grounds			742,150	742,150		742,150	(742,150)				34
35	Rent-Equipment & Vehicles			56,371	56,371		56,371	(17,865)	38,506			35
36	Other (specify):*											36
37	TOTAL Ownership			1,313,271	1,313,271		1,313,271	(37,619)	1,275,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,169	74,436	133,605		133,605	7,812	141,417			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		59,169	182,293	241,462		241,462	7,812	249,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,765,100	567,711	3,612,621	6,945,432		6,945,432	(641,903)	6,303,529			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	BHF 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	6,190	30		9
10	Interest and Other Investment Income	(63,577)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,029)	2		13
14	Non-Care Related Interest	(1,432)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(53,217)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(12,174)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (125,239)		\$	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)	(516,664)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (516,664)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (641,903)		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# 0036632

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	A. General Services	0	0	0	0	0	0	0	0	0	0	0	0	1
	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	
2	Food Purchase	(1,029)	0	0	0	0	0	0	0	0	0	0	(1,029)	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	15	0	0	0	0	0	0	0	0	15	5
6	Maintenance	0	0	9,469	0	0	0	0	0	0	0	0	9,469	6
7	Other (specify):*	0	0	80	0	0	0	0	0	0	0	0	80	7
8	TOTAL General Services	(1,029)	0	9,564	0	0	0	0	0	0	0	0	8,535	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	59,026	0	0	0	0	0	0	0	0	59,026	10
10a	Therapy	0	5,339	5,493	1,737	0	0	0	0	0	0	0	12,569	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	TOTAL Health Care and Programs	0	5,339	64,519	1,737	0	71,595	16						
	C. General Administration													
17	Administrative	0	0	(391,555)	0	0	0	0	0	0	0	0	(391,555)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(308,551)	0	0	0	0	0	0	0	0	(308,551)	19
20	Fees, Subscriptions & Promotions	(12,174)	0	4,067	0	0	0	0	0	0	0	0	(8,107)	20
21	Clerical & General Office Expenses	(53,217)	0	(34,310)	0	0	0	0	0	0	0	0	(87,527)	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	2,040	0	0	0	0	0	0	0	0	2,040	23
24	Travel and Seminar	0	0	3,018	0	0	0	0	0	0	0	0	3,018	24
25	Other Admin. Staff Transportation	0	0	11,785	0	0	0	0	0	0	0	0	11,785	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,542	0	0	0	0	0	0	0	0	2,542	26
27	Other (specify):*	0	0	84,129	0	0	0	0	0	0	0	0	84,129	27
28	TOTAL General Administration	(65,391)	0	(626,835)	0	0	0	0	0	0	0	0	(692,226)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,420)	5,339	(552,752)	1,737	0	(612,096)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	6,190	151,669	0	17,886	0	0	0	0	0	0	0	175,745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(65,009)	545,081	0	58,420	0	0	0	0	0	0	0	538,492	32
33	Real Estate Taxes	0	0	0	8,159	0	0	0	0	0	0	0	8,159	33
34	Rent-Facility & Grounds	0	(742,150)	0	0	0	0	0	0	0	0	0	(742,150)	34
35	Rent-Equipment & Vehicles	0	(29,856)	0	11,991	0	0	0	0	0	0	0	(17,865)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(58,819)	(75,256)	0	96,456	0	(37,619)	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	7,812	0	0	0	0	0	0	0	0	0	7,812	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	7,812	0	0	0	0	0	0	0	0	0	7,812	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(125,239)	(62,105)	(552,752)	98,193	0	(641,903)	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
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CAREPLUS REHAB	SKOKIE	THERAPY
				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	\$ 742,150	COUNTRYSIDE HEALTHCARE CENTER, LLC		\$	(742,150)	1
2	V	30 SL DEPRECIATION		" "		147,798	147,798	2
3	V	32 INTEREST		" "		542,663	542,663	3
4	V							4
5	V							5
6	V							6
7	V	10A THERAPY SERVICES	50,869	CAREPLUS REHABILITATIVE SERVICES		56,208	5,339	7
8	V	39 ANCILLARY THERAPY	74,435	" "		82,247	7,812	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		" "		2,418	2,418	11
12	V							12
13	V							13
14	Total		\$ 897,310			\$ 835,205	\$ * (62,105)	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	17 MANAGEMENT FEES	\$ 516,000	CAREPLUS MGMT. INC.		\$	\$ (516,000) 15
16	V	19 ADMIN. CONSULT. FEES	282,000	" "			(282,000) 16
17	V	19 DATA PROCESS FEES	36,660	" "			(36,660) 17
18	V	21 CLERICAL FEES	156,000	" "			(156,000) 18
19	V			" "			
20	V			" "			
21	V			" "			
22	V			" "			
23	V	5 UTILITIES		" "		15	15 23
24	V	6 MAINT AND REPAIR		" "		1,701	1,701 24
25	V	6 MAINTENANCE SALARIES		" "		7,768	7,768 25
26	V	7 SECURITY		" "		80	80 26
27	V	10 NURSING SALARIES		" "		59,026	59,026 27
28	V	10A THERAPY SALARIES		" "		5,493	5,493 28
29	V	17 ADMIN. SALARIES		" "		124,445	124,445 29
30	V	19 PROFESSIONAL FEES		" "		10,109	10,109 30
31	V	20 ADVERTISING		" "		4,067	4,067 31
32	V	21 TOTAL OFFICE		" "		31,118	31,118 32
33	V	21 CLERICAL SALARIES		" "		90,572	90,572 33
34	V	23 SEMINARS		" "		2,040	2,040 34
35	V	24 TRAVEL		" "		3,018	3,018 35
36	V	25 TRANSPORTATION		" "		11,785	11,785 36
37	V	26 INSURANCE		" "		2,542	2,542 37
38	V	27 EMPLOYEE BENEFITS		" "		84,129	84,129 38
39	Total		\$ 990,660			\$ 437,908	\$ * (552,752) 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.		\$ 17,886	\$	17,886	15
16	V	33 REAL ESTATE TAX		" "		8,159		8,159	16
17	V	32 INTEREST		" "		52,441		52,441	17
18	V	32 INTEREST-TAG 18 PPTY-MTG		" "		5,542		5,542	18
19	V	32 INTEREST-CP REHAB-EQ LOAN		" "		437		437	19
20	V	35 EQUIPMENT RENT		" "		11,991		11,991	20
21	V	10A REHAB SUPPLIES		" "		1,737		1,737	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		\$			\$ 98,193	\$ *	98,193	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: 01/01/2007 Ending: 12/31/2007

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	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	SHERWIN RAY	PRESIDENT	ADMINISTRATIVE	41.24	SEE ATTACHED	60	8.70	SALARY	23,954	17-7	2
3			FINANCE		SCHEDULE						3
4	JACOB BAKST	DIR OPERATIONS	ADMINISTRATIVE	26.65		60	8.70	SALARY	23,954	17-7	4
5			CONSULTING								5
6	ROSLYN INDICH	CLERICAL	CLERICAL	2.54		60	8.70	SALARY	7,177	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 55,085		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:

01/01/2007

Ending: 2/31/2007

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	445,767	11	\$ 100	\$ 64,715	\$ 15	1
2	6	MAINT & REPAIRS	CENSUS DAYS	445,767	11	11,715	64,715	1,701	2
3	6	MAINTENANCE SALARIES	CENSUS DAYS	445,767	11	53,507	64,715	7,768	3
4	7	SECURITY	CENSUS DAYS	445,767	11	548	64,715	80	4
5	10	NURSING SALARIES	CENSUS DAYS	445,767	11	406,577	64,715	59,026	5
6	10A	THERAPY SALARIES	CENSUS DAYS	445,767	11	37,834	64,715	5,493	6
7	17	ADMIN. SALARIES	CENSUS DAYS	445,767	11	857,197	64,715	124,445	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	445,767	11	69,630	64,715	10,109	8
9	20	ADVERTISING	CENSUS DAYS	445,767	11	28,013	64,715	4,067	9
10	21	TOTAL OFFICE	CENSUS DAYS	445,767	11	214,347	64,715	31,118	10
11	21	CLERICAL SALARIES	CENSUS DAYS	445,767	11	623,871	64,715	90,572	11
12	23	SEMINARS	CENSUS DAYS	445,767	11	14,052	64,715	2,040	12
13	24	TRAVEL	CENSUS DAYS	445,767	11	20,788	64,715	3,018	13
14	25	TRANSPORTATION	CENSUS DAYS	445,767	11	81,177	64,715	11,785	14
15	26	INSURANCE	CENSUS DAYS	445,767	11	17,511	64,715	2,542	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	445,767	11	579,494	64,715	84,129	16
17	30	DEPRECIATION (SL)	CENSUS DAYS	445,767	11	123,201	64,715	17,886	17
18	33	REAL ESTATE TAX	CENSUS DAYS	445,767	11	56,199	64,715	8,159	18
19	32	INTEREST	CENSUS DAYS	445,767	11	361,224	64,715	52,441	19
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	445,767	11	38,177	64,715	5,542	20
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	445,767	11	3,007	64,715	437	21
22	35	EQUIPMENT RENT	CENSUS DAYS	445,767	11	82,599	64,715	11,991	22
23	10A	REHAB SUPPLIES	CENSUS DAYS	445,767	11	11,963	64,715	1,737	23
24									24
25	TOTALS				\$ 3,692,731	\$ 1,978,986		\$ 536,101	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**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 CENTER,LLC						\$	\$			\$	1						
2	LAKE FOREST BANK		X	MORTGAGE	\$55,766.87	2/9/06	8,000,000	7,752,556	2/9/09	6.7500	535,680	2						
3	LOAN FEES		X	LOAN FEES	W/O OVER LOAN		101,520	95,141			3,384	3						
4	CIB BANK		X	CAPITAL IMPROVEMENTS		01/04	540,000	7,881		PRIME+	3,599	4						
5												5						
	Working Capital																	
6	CAREPLUS MANAGEMENT ALLOCATION										58,420	6						
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING							2,917	7						
8	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS										2,418	8						
9	TOTAL Facility Related						\$ 8,641,520	\$ 7,855,578			\$ 606,418	9						
	B. Non-Facility Related*																	
10												10						
11	IRS,IDR,ETC		X	LATE FEES							1,432	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,432	14						
15	TOTALS (line 9+line14)						\$ 8,641,520	\$ 7,855,578			\$ 607,850	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 2006 report.	\$	500,308	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.)	\$	480,009	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(20,299)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	484,809	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	464,510	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	434,119	8
	2003	444,090	9
	2004	478,584	10
	2005	495,354	11
	2006	480,009	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2006 TAX BILL.

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036632

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 2006 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 2006.

(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>29-13-100-001-0000</u>	<u>NURSING HOME</u>	\$ <u>480,008.58</u>	\$ <u>480,008.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>480,008.58</u>	\$ <u>480,008.58</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 HEALTHCARE CENTER

0036632

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	TOTALS	132,928		\$ 392,750	3

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

0036632

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	197	1998		\$ 5,408,525	\$ 138,675	39	\$ 138,675	\$	\$ 1,334,882	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1991	24,648	782	31.5	782		13,181	9
10	LEASEHOLD IMPROVEMENTS		1992	28,172	894	31.5	894		13,903	10
11	LEASEHOLD IMPROVEMENTS		1993	11,940	337	31.5	337		5,243	11
12	LEASEHOLD IMPROVEMENTS		1994	4,878	125	39	125		1,669	12
13	TILE / ROOF VENTS		1995	16,191	416	39	416		5,205	13
14	WALL / WATER PANEL		1995	4,199	107	39	107		1,322	14
15	LANDSCAPING/PARKING LOT REPAIRS		1995	13,614	908	15	908		11,349	15
16	ROOF REPAIRS		1996	13,369	342	39	342		3,983	16
17	SINK		1996	683	18	39	18		207	17
18	ROOF-TOP A/C UNIT		1996	5,100	131	39	131		1,468	18
19	WINDOWS		1996	1,080	28	39	28		311	19
20	WINDOWS		1997	14,040	360	39	360		3,793	20
21	WALK-IN FREEZER		1997	3,196	82	39	82		851	21
22	WINDOWS		1998	8,370	214	39	214		2,074	22
23	FLOORING / TILE / CARPETING		1998	3,396	87	39	87		840	23
24	CEILING TILES		1998	2,213	57	39	57		525	24
25	ROOF REPAIRS / ROOFTOP A/C		1999	33,838	868	39	868		7,269	25
26	ROOF REPAIRS		2000	13,505	346	39	346		2,725	26
27	INSTALLATION CORNICES & SHEERS		2000	3,280	119	27.5	119		898	27
28	DRAPERY PANELS		2000	2,170	166	20	109	(57)	872	28
29	CARPETING OFFICES		2001	1,814	1	20	91	90	637	29
30	INSTALLED ROOF TOP UNIT		2001	6,992	254	27.5	254		1,535	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING, CEILING		2003	100,619	3,659	27.5	3,659		17,228	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS		2003	4,501	519	20	225	(294)	1,125	32
33	REPLACE FIRE ALARM SYSTEM		2003	5,204	189	27.5	189		811	33
34	NEW DURO-LAST ROOFING SYSTEM		2003	28,100	1,022	27.5	1,022		4,131	34
35	PAINTING		2004	4,100	472	20	205	(267)	820	35
36	BATHROOMS AND OFFICE REMODELING		2004	43,350	1,576	27.5	1,576		4,794	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 HEALTHCARE CENTER

0036632

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 293	37
38	REPLACEMENT OF DECK PANELS	2005	74,108	2,695	27.5	2,695		7,973	38
39	INSTALLED DELAYED EGRESS	2005	6,875	250	27.5	250		719	39
40	VARIOUS WALKS	2006	5,000	333	15	333		666	40
41	INSTALLED EXHAUST FAN & SMOKE DAMPERS	2006	12,132	441	27.5	441		643	41
42	TUCKPOINTING	2006	4,850	177	27.5	177		258	42
43	FLOORING RESIDENT & BATHROOMS	2006	43,156	1,569	27.5	1,569		2,288	43
44	PARKING LOT IMPROVEMENTS-ASPHALT	2007	20,500	1,025	15	1,025		1,025	44
45	CUBICLE CURTAINS-RESIDENT ROOMS & BATHROOMS	2007	13,978	2,796	5	2,796		2,796	45
46	INSTALL CORRIDOR DOORS, HINGES & CLOSERS	2007	3,420	47	27.5	47		47	46
47	INSTALL NEW AIR CONDITION UNIT-COMPUTER ROOM	2007	2,531	506	5	506		506	47
48	REPLACE FEDDER ROOF TOP UNIT IN DINNING ROOM	2007	5,739	78	27.5	78		78	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	27.5	9,123			56
57									57
58	CAREPLUS MGMT								58
59	BUILDING-TAG-18 PROPERTIES	2004	69,195	2,330	39	2,330			59
60	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	27,184	1,380	39	1,380			60
61	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		9		9			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)		\$ 6,359,111	\$ 175,642		\$ 175,114	\$ (528)	\$ 1,460,943	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	\$ 303,292	\$ 19,228	\$ 26,367	\$ 7,139	3-15	\$ 189,190	71
72	Current Year Purchases	2,812	562	141	(421)	10	141	72
73	Fully Depreciated Assets	88,819					88,819	73
74	RELATED PARTY SL DEPRECIATION		17,988	17,988				74
75	TOTALS	\$ 394,923	\$ 37,778	\$ 44,496	\$ 6,718		\$ 278,150	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	FACILITY	DODGE RAM BR 150	2006	\$ 10,132	\$ 2,026	\$ 2,026	\$	5	\$ 4,052	76
77										77
78										78
79										79
80	TOTALS			\$ 10,132	\$ 2,026	\$ 2,026	\$		\$ 4,052	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)	\$ 7,156,916	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 215,446	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,636	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,190	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,743,145	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: \$ \$ 48,122 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</u>	<u>2006 CHEVY EXPRESS</u>	\$ <u>687.44</u>	\$ <u>8,249</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 687.44	\$ 8,249	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	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	\$		\$ 48,956	\$		\$ 48,956	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			203			203	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			25,277			25,277	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				59,169		59,169	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 74,436	\$ 59,169		\$ 133,605	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 32,383	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,635)	3,430,379		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	153,107		6
7	Other Prepaid Expenses	76,184		7
8	Accounts Receivable (owners or related parties)	2,368,965		8
9	Other(specify): Real Estate Tax Escrow	191,991		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,253,009	\$	10
	B. Long-Term Assets			
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	597,014		15
16	Equipment, at Historical Cost	405,055		16
17	Accumulated Depreciation (book methods)	(507,490)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 494,579	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,747,588	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,654,688	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,432		28
29	Short-Term Notes Payable	1,382,101		29
30	Accrued Salaries Payable	170,062		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,586		31
32	Accrued Real Estate Taxes(Sch.IX-B)	484,809		32
33	Accrued Interest Payable	6,079		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,763,757	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,763,757	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,983,831	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,747,588	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,016,598	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,016,602	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	967,229	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)	\$ 967,229	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,983,831	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	\$ 7,840,795	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,840,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,289	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,289	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63,577	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63,577	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,912,661	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,131,054	31
32	Health Care	2,239,973	32
33	General Administration	2,019,672	33
	B. Capital Expense		
34	Ownership	1,313,271	34
	C. Ancillary Expense		
35	Special Cost Centers	133,605	35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,945,432	40
41	Income before Income Taxes (line 30 minus line 40)**	967,229	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 967,229	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: **01/01/2007**

Ending: **12/31/2007**

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	1,884	2,112	\$ 75,244	\$ 35.63	1
2	Assistant Director of Nursing	2,422	2,744	82,620	30.11	2
3	Registered Nurses	7,984	8,315	216,884	26.08	3
4	Licensed Practical Nurses	27,531	28,631	634,161	22.15	4
5	CNAs & Orderlies	52,233	58,241	479,285	8.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,209	6,137	85,709	13.97	8
9	Activity Director	2,072	2,147	28,345	13.20	9
10	Activity Assistants	8,441	9,289	67,512	7.27	10
11	Social Service Workers	2,007	2,547	39,074	15.34	11
12	Dietician					12
13	Food Service Supervisor	2,003	2,118	35,093	16.57	13
14	Head Cook	5,493	6,147	53,908	8.77	14
15	Cook Helpers/Assistants	11,930	13,408	97,863	7.30	15
16	Dishwashers					16
17	Maintenance Workers	7,744	8,400	88,393	10.52	17
18	Housekeepers	21,049	23,003	172,897	7.52	18
19	Laundry	7,733	8,437	62,725	7.43	19
20	Administrator	2,017	2,176	89,833	41.28	20
21	Assistant Administrator	1,982	2,170	45,969	21.18	21
22	Other Administrative					22
23	Office Manager	1,203	1,326	14,995	11.31	23
24	Clerical	2,277	2,348	41,076	17.49	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	1,983	2,132	17,665	8.29	31
32	Other Health Care(specify)	19,009	20,084	335,849	16.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,206	211,912	\$ 2,765,100 *	\$ 13.05	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	\$ 9,606	1-3	35
36	Medical Director	O	19,500	9-3	36
37	Medical Records Consultant	N	1,128	10-3	37
38	Nurse Consultant	T	0	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	709	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,883		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		N/A	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	\$ 89,833	Workers' Compensation Insurance	\$ 53,421	IDPH License Fee	\$	
WILLIE WILSON	ASST ADMIN	0	45,969	Unemployment Compensation Insurance	63,946	Advertising: Employee Recruitment	7,482	
				FICA Taxes	208,429	Health Care Worker Background Check	12	
				Employee Health Insurance	12,766	(Indicate # of checks performed <u>116</u>)		
				Employee Meals	0	Patient Background Checks	155	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	6,106	MARKETING/ADV/PROMO	12,174	
				EMPLOYEE PHYSICAL EXAMS	521	LICENSES/DUES/SUBSCRIPTIONS	2,426	
				PENSION/PROFIT SHARING PLANS	3,405	MGMT CO ALLOC	4,067	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(12,174)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,802	TOTAL (agree to Schedule V, line 22, col.8)	\$ 348,594	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,987	
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 MANAGEMENT MANAGEMENT FEES			\$ 516,000			\$	Out-of-State Travel	\$
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 516,000				MGMT CO ALLOC	3,018
C. Professional Services							Seminar Expense	1,945
Vendor/Payee	Type		Amount					
CAREPLUS MANAGEMENT	DATA PROCESSING		\$ 36,660				Entertainment Expense	()
AMERICAN DATA	DATA PROCESSING		2,886				(agree to Sch. V, line 24, col. 8)	
NATIONAL DATACARE	DATA PROCESSING		2,338				TOTAL	\$ 4,963
ACHIEVE HEALTHCARE	DATA PROCESSING		3,392					
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		5,469					
CAREPLUS MANAGEMENT	ADMIN. CONSULTANT		282,000					
KRUPNICK,BOKOR,KAGDA,LTD	ACCOUNTING FEES		26,200					
MEYER MAGENCE	LEGAL FEES		2,500					
ECONOCARE	PURCHASE CONSULTANT		3,546					
PERSONNEL PLANNER	UC CONSULTANT		1,572					
RICHARD PEELO	MEDICARE CONSULTANT		4,800					
EMDEON BUSINESS SERVICE	DATA PROCESSING		370					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 371,733	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

0036632

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. \$ 101 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. \$ 107,857
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees