



Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,762	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	11,560	1,934	6,468	19,962	8
9	SNF/PED					9
10	ICF	38,993	6,524	3,472	48,989	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,553	8,458	9,940	68,951	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.01%

D. How many bed-hold days during this year were paid by the Department? 13 (Do not include bed-hold days in Section B.)

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

NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 131 and days of care provided 5,438

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICE)

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE** # **0040931** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

**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
	<b>A. General Services</b>										
1	Dietary	352,785	31,088	29,148	413,021		413,021	(5,115)	407,906		1
2	Food Purchase		314,367		314,367		314,367	(4,333)	310,034		2
3	Housekeeping	312,980	56,794		369,774		369,774	(686)	369,088		3
4	Laundry	45,919	34,026	6,159	86,104		86,104	10,602	96,706		4
5	Heat and Other Utilities			299,536	299,536		299,536		299,536		5
6	Maintenance	50,656	63,786	71,266	185,708		185,708	(4,619)	181,089		6
7	Other (specify):*			55,393	55,393		55,393		55,393		7
8	<b>TOTAL General Services</b>	<b>762,340</b>	<b>500,061</b>	<b>461,502</b>	<b>1,723,903</b>		<b>1,723,903</b>	<b>(4,151)</b>	<b>1,719,752</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,500	13,500		13,500		13,500		9
10	Nursing and Medical Records	4,342,313	353,335	132,016	4,827,664		4,827,664	(54,015)	4,773,649		10
10a	Therapy	12,399		12,433	24,832		24,832		24,832		10a
11	Activities	130,264	12,907	20,837	164,008		164,008	215	164,223		11
12	Social Services	111,783		11,037	122,820		122,820		122,820		12
13	CNA Training										13
14	Program Transportation			2,071	2,071		2,071		2,071		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>4,596,759</b>	<b>366,242</b>	<b>191,894</b>	<b>5,154,895</b>		<b>5,154,895</b>	<b>(53,800)</b>	<b>5,101,095</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	205,269		981,034	1,186,303		1,186,303	(984,740)	201,563		17
18	Directors Fees										18
19	Professional Services			443,832	443,832		443,832	(217,151)	226,681		19
20	Dues, Fees, Subscriptions & Promotions			144,987	144,987		144,987	(112,186)	32,801		20
21	Clerical & General Office Expenses	281,970	59,032	56,162	397,164		397,164	212,320	609,484		21
22	Employee Benefits & Payroll Taxes			1,036,059	1,036,059		1,036,059		1,036,059		22
23	Inservice Training & Education			10,330	10,330		10,330		10,330		23
24	Travel and Seminar			1,446	1,446		1,446	16,377	17,823		24
25	Other Admin. Staff Transportation			7,040	7,040		7,040		7,040		25
26	Insurance-Prop.Liab.Malpractice			90,629	90,629		90,629	22,413	113,042		26
27	Other (specify):*			1,031,164	1,031,164		1,031,164	(1,031,164)			27
28	<b>TOTAL General Administration</b>	<b>487,239</b>	<b>59,032</b>	<b>3,802,683</b>	<b>4,348,954</b>		<b>4,348,954</b>	<b>(2,094,131)</b>	<b>2,254,823</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,846,338</b>	<b>925,335</b>	<b>4,456,079</b>	<b>11,227,752</b>		<b>11,227,752</b>	<b>(2,152,082)</b>	<b>9,075,670</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	23,445
	REPAIRS & MAINTENANCE	5,703
		0
		29,148
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	6,159
		0
		6,159
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	83,548
	ELECTRICITY	119,766
	WATER	96,222
	CABLE TV - LOBBY	0
		0
		299,536
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	36,685
	PAINTING & DECORATING	4,414
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,693
	ELEVATOR MAINTENANCE & REPAIR	6,292
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,912
	FIRE SERVICE	9,270
		0
		0
		0
		0
		71,266
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	51,564
	SECURITY SERVICE	3,829
		0
		0
		55,393
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,500
		13,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	4,187
	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	1,536
	PHARMACY CONSULTANT XVIII B 39-2	2,400
	UTILIZATION REVIEW FEES XVIII B 46-2	4,500
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	119,393
		0
		0
		132,016
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	12,433
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		12,433
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	16,999
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,838
		0
		20,837
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	9,250
	SOCIAL WORKER XVIII B 45-2	1,787
		0
		11,037
<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	2,071
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	981,034
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	23,975
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	419,857
		0
		443,832
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	71,722
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,085
	EMPLOYEE WANT ADS XIX F	9,106
	CONTRIBUTIONS VI 20 XIX F	98
	DUES & SUBSCRIPTIONS XIX F	15,158
	LICENSES & PERMITS XIX F	2,056
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	23,334
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,228
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,700
	PATIENT BACKGROUND CHECKS XIX F	3,500
		144,987
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	635
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	19,707
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	31,599
	MESSENGER SERVICE	4,221
		0
		56,162

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	439,871
	UNEMPLOYMENT COMPENSATION XIX D	65,512
	WORKERS COMPENSATION INSURANC XIX D	126,473
	HOSPITALIZATION INSURANCE XIX D	373,658
	EMPLOYEE BENEFITS - OTHER XIX D	9,647
	EMPLOYEE PHYSICAL EXAMS XIX D	5,871
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,027
	CHICAGO HEAD TAX XIX D	0
		0
		1,036,059
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	10,330
		10,330
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,446
		1,446
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,040
		7,040
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	90,629
		90,629
27	<b>OTHER</b>	
	BAD DEBTS VI 24	1,031,164
		1,031,164

GRAND TOTAL COLUMN 3 OTHER

4,456,079

**COUNTRYSIDE CARE CENTRE  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	314,367
LESS SALES TAX	<u>(4,333)</u>
NET FOOD	310,034

TOTAL PATIENT CENSUS	68,951
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	206,853

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	206,853
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	206,853

NET FOOD	310,034
DIVIDE TOTAL MEALS/YEAR	<u>206,853</u>

COST PER MEAL	1.50
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

=====

Facility Name &amp; ID Number

COUNTRYSIDE CARE CENTRE

#0040931

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			237,565	237,565		237,565	122,377	359,942			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			264,796	264,796		264,796	282,694	547,490			32
33	Real Estate Taxes			192,333	192,333		192,333		192,333			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(716,121)	46,729			34
35	Rent-Equipment & Vehicles			47,968	47,968		47,968	13,052	61,020			35
36	Other (specify):* MTG INSURANCE							22,958	22,958			36
37	<b>TOTAL Ownership</b>			1,505,512	1,505,512		1,505,512	(275,040)	1,230,472			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		369,791	1,158,771	1,528,562		1,528,562		1,528,562			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,644	113,644		113,644		113,644			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		369,791	1,272,415	1,642,206		1,642,206		1,642,206			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,846,338	1,295,126	7,234,006	14,375,470		14,375,470	(2,427,122)	11,948,348			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>BHF 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	(113,771)	30		9
10	Interest and Other Investment Income	(885)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,333)	2		13
14	Non-Care Related Interest		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	(19,707)	21		18
19	Entertainment	(71,722)	20		19
20	Contributions	(3,326)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(51,365)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,031,164)	27		24
25	Fund Raising, Advertising and Promotional	(15,085)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(23,334)	20		28
29	Other-Attach Schedule	(8,498)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,343,190)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

**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)	(1,083,932)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,083,932)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,427,122)		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	
		<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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0040931

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (3,087)	6	1
2	VACATION ACCRUAL	(5,115)	1	2
3	VACATION ACCRUAL	(686)	3	3
4	VACATION ACCRUAL	10,602	4	4
5	VACATION ACCRUAL	(1,532)	6	5
6	VACATION ACCRUAL	(968)	10	6
7	VACATION ACCRUAL	215	11	7
8	VACATION ACCRUAL	(3,706)	17	8
9	VACATION ACCRUAL	(163)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(258)	19	11
12	MARKETING CONSULTANT	(1,800)	19	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>	(8,498)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(5,115)	0	0	0	0	0	0	0	0	0	0	(5,115)	1
2	Food Purchase	(4,333)	0	0	0	0	0	0	0	0	0	0	(4,333)	2
3	Housekeeping	(686)	0	0	0	0	0	0	0	0	0	0	(686)	3
4	Laundry	10,602	0	0	0	0	0	0	0	0	0	0	10,602	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,619)	0	0	0	0	0	0	0	0	0	0	(4,619)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,151)</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>0</b>	<b>(4,151)</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	(968)	0	0	(53,047)	0	0	0	0	0	0	0	(54,015)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	215	0	0	0	0	0	0	0	0	0	0	215	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>(753)</b>	<b>0</b>	<b>0</b>	<b>(53,047)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(53,800)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(3,706)	0	(735,606)	0	0	(245,428)	0	0	0	0	0	(984,740)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(55,423)	32,426	83,073	93	(277,320)	0	0	0	0	0	0	(217,151)	19
20	Fees, Subscriptions & Promotions	(113,467)	0	633	193	455	0	0	0	0	0	0	(112,186)	20
21	Clerical & General Office Expenses	(19,870)	0	19,340	3,398	209,452	0	0	0	0	0	0	212,320	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,683	4,953	5,741	0	0	0	0	0	0	16,377	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,007	2,575	17,831	0	0	0	0	0	0	22,413	26
27	Other (specify):*	(1,031,164)	0	0	0	0	0	0	0	0	0	0	(1,031,164)	27
28	<b>TOTAL General Administration</b>	<b>(1,223,630)</b>	<b>32,426</b>	<b>(624,870)</b>	<b>11,212</b>	<b>(43,841)</b>	<b>(245,428)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,094,131)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,228,534)</b>	<b>32,426</b>	<b>(624,870)</b>	<b>(41,835)</b>	<b>(43,841)</b>	<b>(245,428)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,152,082)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(113,771)	230,289	582	239	5,038	0	0	0	0	0	0	122,377	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(885)	283,579	0	0	0	0	0	0	0	0	0	282,694	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	0	0	46,729	0	0	0	0	0	0	(716,121)	34
35	Rent-Equipment & Vehicles	0	0	6,908	4,127	2,017	0	0	0	0	0	0	13,052	35
36	Other (specify):*	0	22,958	0	0	0	0	0	0	0	0	0	22,958	36
37	<b>TOTAL Ownership</b>	<b>(114,656)</b>	<b>(226,024)</b>	<b>7,490</b>	<b>4,366</b>	<b>53,784</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(275,040)</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	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,343,190)</b>	<b>(193,598)</b>	<b>(617,380)</b>	<b>(37,469)</b>	<b>9,943</b>	<b>(245,428)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,427,122)</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
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 762,850	COUNTRYSIDE HEALTH CARE CENTRE		\$	(762,850)	1
2	V	36 MORTGAGE INSURANCE		"		22,958	22,958	2
3	V	30 DEPRECIATION-BLDG/IMP		"		229,833	229,833	3
4	V	30 DEPRECIATION - EQPT/FURN		"		456	456	4
5	V	32 AMORTIZATION - MTG COST		"		1,282	1,282	5
6	V	32 INTEREST - MORTGAGE		"		248,095	248,095	6
7	V	32 INTEREST - OTHER		"		34,202	34,202	7
8	V	19 ACCOUNTING FEES		"		12,029	12,029	8
9	V	19 DATA PROCESSING		"		203	203	9
10	V	19 LEGAL FEES		"		15,000	15,000	10
11	V	19 OTHER PROFESSIONAL		"		5,194	5,194	11
12	V							12
13	V							13
14	Total		\$ 762,850			\$ 569,252	\$ * (193,598)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 83,073	\$ 83,073
16	V	20 DUES & SUBSCRIPTIONS		"		633	633
17	V	21 CLERICAL		"		19,340	19,340
18	V	24 TRAVEL		"		5,683	5,683
19	V	26 INSURANCE		"		2,007	2,007
20	V	35 RENT-EQPT & VEHICLE		"		6,908	6,908
21	V	17 ADMINISTRATIVE	735,606	"			(735,606)
22	V	30 DEPRECIATION		"		582	582
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 735,606			\$ 118,226	\$ * (617,380)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 119,393	CARLYLE NURSING ASSOCIATES, LLC		\$ 66,346	\$ (53,047)
16	V	19 PROFESSIONAL FEES		"		93	93
17	V	20 DUES & SUBSCRIPTIONS		"		193	193
18	V	21 CLERICAL		"		3,398	3,398
19	V	24 TRAVEL		"		4,953	4,953
20	V	26 INSURANCE		"		2,575	2,575
21	V	30 DEPRECIATION		"		239	239
22	V	34 RENT		"			
23	V	35 RENT - EQPT & VEHICLE		"		4,127	4,127
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 119,393			\$ 81,924	\$ * (37,469)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 294,624	THE KENSINGTON GROUP, LLC		\$ 17,304	\$ (277,320)
16	V	20 DUES & SUBSCRIPTIONS		"		455	455
17	V	21 CLERICAL		"		209,452	209,452
18	V	24 TRAVEL		"		5,741	5,741
19	V	26 INSURANCE		"		17,831	17,831
20	V	30 DEPRECIATION		"		5,038	5,038
21	V	34 RENT		"		46,729	46,729
22	V	35 RENT -EQPT & VEHICLES		"		2,017	2,017
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 294,624			\$ 304,567	\$ * 9,943

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$ 245,428	CHESTERFIELD, LLC		\$	\$ (245,428)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 245,428			\$ 0	\$ * (245,428)

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,373	7	\$ 431,773	\$ 68,951	\$ 83,073	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	68,951	633	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	68,951	19,340	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	68,951	5,683	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	68,951	2,007	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	358,373	7	35,906	68,951	6,908	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	68,951	582	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 614,484	\$	\$ 118,226	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 66,346	\$ 66,346	1	\$ 66,346	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	744		68,951	93	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	1,552		68,951	193	3
4	21	CLERICAL	PATIENT DAYS	554,294	27,317		68,951	3,398	4
5	24	TRAVEL	PATIENT DAYS	554,294	39,814		68,951	4,953	5
6	26	INSURANCE	PATIENT DAYS	554,294	20,700		68,951	2,575	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	1,923		68,951	239	7
8	34	RENT	PATIENT DAYS	554,294			68,951		8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	554,294	33,179		68,951	4,127	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 191,575	\$ 66,346		\$ 81,924	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	\$ 139,104	\$ 68,951	\$ 17,304	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	68,951	455	2	
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	68,951	22,646	3	
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	68,951	5,741	4	
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	68,951	17,831	5	
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	68,951	5,038	6	
7	34	RENT	PATIENT DAYS	554,294	11	375,668	68,951	46,729	7	
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	554,294	11	16,218	68,951	2,017	8	
9									9	
10	21	CLERICAL	DIRECT HOURS	1	1	186,806	186,806	1	186,806	10
11									11	
12									12	
13									13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,133,511	\$ 186,806	\$ 304,567	25	

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE						\$	\$			\$	1						
2	CAPMARK		X	MORTGAGE	\$60,450.43	12/03	4,826,200	4,564,400	12/38	0.0540	248,095	2						
3	CAPMARK		X	LOAN COST	35 YR AMORT	12/03	52,135	38,420			1,282	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	LOAN - PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	238,555	DEMAND	VARIES	18,829	6						
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	3,937,481	DEMAND	VARIES	278,677	7						
8	MAXSOURCE		X	WORKING CAPITAL			27,165	27,165			1,492	8						
9	TOTAL Facility Related				\$60,450.43		\$ 5,513,089	\$ 8,806,021			\$ 548,375	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,513,089	\$ 8,806,021			\$ 548,375	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 2007 report.	\$	<b>148,500</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>169,483</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>20,983</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>171,350</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>192,333</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>123,696</b>	<b>8</b>
	<b>2004</b>	<b>130,117</b>	<b>9</b>
	<b>2005</b>	<b>139,081</b>	<b>10</b>
	<b>2006</b>	<b>146,807</b>	<b>11</b>
	<b>2007</b>	<b>169,483</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	<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 2007 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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-19-176-009</u>	<u>NURSING HOME</u>	\$ <u>169,483.38</u>	\$ <u>169,483.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>169,483.38</u>	\$ <u>169,483.38</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207	1981		\$ 2,111,156	\$	30	\$ 70,372	\$ 70,372	\$ 1,922,010	4
5	754 BASIS ADJ		1992	403,542	12,811	31.5	12,811		211,382	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	*****RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE*****									
10	BUILDING IMPROVEMENTS		1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS		1983	26,282		15				11
12	VINYL TILING		1984	76,250		20			76,250	12
13	ROOF REPAIR		1985	6,644		20			6,644	13
14	VARIOUS IMPROVEMENTS		1986	1,609		15			1,609	14
15	VARIOUS IMPROVEMENTS		1987	36,433	1,157	31.5	1,157		37,177	15
16	BLACK TOP PAVING		1988	1,594		15			1,594	16
17	HOT WATER PIPING		1988	5,837	186	31.5	186		3,740	17
18	ROOFING IMPROVEMENTS		1989	51,879	1,647	31.5	1,647		32,460	18
19	SHOWER STALLS		1990	7,000	222	31.5	222		4,107	19
20	PAVING		1990	7,930		15			7,930	20
21	VARIOUS IMPROVEMENTS		1991	24,486	778	31.5	778		19,641	21
22	VARIOUS IMPROVEMENTS		1992	43,773	1,388	31.5	1,388		22,797	22
23	VARIOUS IMPROVEMENTS		1993	13,286	423	31.5	423		6,677	23
24	VARIOUS IMPROVEMENTS		1993	40,598	1,041	39	1,041		15,917	24
25	VARIOUS IMPROVEMENTS		1994	214,320	5,496	39	5,496		77,883	25
26	VARIOUS IMPROVEMENTS		1994	62,476	4,165	15	4,165		60,414	26
27	KITCHEN REMODEL/SIGNS		1995	32,836	842	39	842		11,720	27
28	ELECTRICAL & LIGHTING		1995	31,634	811	39	811		10,032	28
29	ROOFING/DOORS/DUCTWORK		1995	15,211	391	39	391		4,841	29
30	ROOF REPAIRS/FIRE DAMPERS		1996	4,300	111	39	111		1,418	30
31	BLACK TOP PAVING		1996	3,400	87	39	87		1,055	31
32	DUCTWORK		1996	8,584	220	39	220		2,649	32
33	REMOVE & REPLACE HVAC ROOF UNITS		1998	28,363	728	39	728		7,483	33
34	ROOF REPAIRS - PATCHING		1998	6,500	166	39	166		1,815	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST		1998	3,987	102	39	102		1,118	35
36	BOILER		1998	6,556	168	39	168		1,785	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	\$ 58,243	\$ 2,118	27.5	\$ 2,118	\$	\$ 21,092	37
38	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		9,877	38
39	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404	27.5	404		3,956	39
40	DINING RMS/WASHROOM-REMODEL/NEW ROOF	1999	165,984	6,036	27.5	6,036		58,593	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		13,639	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		9,084	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,625	27.5	4,625		43,738	43
44	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	947	27.5	947		8,879	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,665	27.5	30,665		282,348	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		23,605	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		1,702	47
48	DOORS/LAUNDRY RM/CORRIDOR-REMODEL	2000	64,257	2,336	27.5	2,336		20,150	48
49	ELEVATOR OPERATION PANEL	2000	4,490	164	27.5	164		1,407	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		2,335	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		2,631	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		1,608	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		25,261	53
54	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		2,595	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		7,007	55
56	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		1,866	56
57	PARKING LOT EXPANSION	2000	35,624	1,296	27.5	1,296		10,739	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		27,646	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	841	15	841		7,155	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		20,087	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		4,342	61
62	STIR FREE LINT FILTER	2000	1,399	51	27.5	51		419	62
63	NEW ROOF	2000	20,995	764	27.5	764		6,201	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		30,608	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		975	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	407	27.5	407		3,280	66
67	ROOF TOP HVAC UNIT	2000	7,350	268	27.5	268		2,148	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		31,887	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	607	27.5	607		4,774	69
70	TOTAL (lines 4 thru 69)		\$ 5,426,228	\$ 110,037		\$ 180,409	\$ 70,372	\$ 3,310,140	70

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,426,228	\$ 110,037		\$ 180,409	\$ 70,372	\$ 3,310,140	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		945	2
3	INSTALL HYDRAULIC PUMPING UNIT - KITCHEN ELEVATOR	2001	7,495	272	27.5	272		2,126	3
4	REPLACE WATER CLOSET 7 FLUSH VALVES - KITCHEN	2001	7,737	282	27.5	282		2,144	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		792	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	67	27.5	67		499	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	246	27.5	246		1,738	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	192	27.5	192		1,342	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HEATER	2002	14,988	545	27.5	545		3,792	9
10	SHOWER ROOM REPAIRS, REMOVE OLD & FURNISH/INSTALL NEW	2002	26,388	959	27.5	959		6,675	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	84	27.5	84		523	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		459	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	56	27.5	56		333	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,832	15	5,832		38,129	14
15	F&I ONE INFRARED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		276	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		266	16
17	INSTALL WATER SOFTENER	2003	2,400	88	27.5	88		476	17
18	2-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		1,905	18
19	SUPPLY & INSTALL WIRING FOR NEW 208 VOLT FREEZER	2003	1,651	60	27.5	60		318	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602, 611 614, 705, 707	2003	3,666	134	27.5	134		672	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	922	27.5	922		4,191	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	83	27.5	83		360	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	132	27.5	132		581	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PROJECT	2004	3,751	250	15	250		1,125	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,950	27.5	2,950		12,662	25
26	COMPRESSOR	2004	2,100	77	27.5	77		327	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		215	27
28	NEW AZT FLOOR TILES FOR RMS 906,812,303,512,313,314	2004	5,590	204	27.5	204		855	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	152	27.5	152		643	29
30	REPLACE FLOOR TILES & WALL TILES IN RMS 502, 505								30
31	506,511,512,514,805, & 807	2005	5,600	203	27.5	203		738	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS-1ST FLR W. WING	2005	28,000	1,018	27.5	1,018		3,690	33
34	TOTAL (lines 1 thru 33)		\$ 5,779,286	\$ 125,640		\$ 196,012	\$ 70,372	\$ 3,398,937	34

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,779,286	\$ 125,640		\$ 196,012	\$ 70,372	\$ 3,398,937	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	162	27.5	162		585	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	1,657	27.5	1,657		5,866	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	3,837	27.5	3,837		13,590	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	454	27.5	454		1,606	5
6	REPLACE SIDE WALKS	2005	4,000	146	27.5	146		503	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	201	27.5	201		662	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	394	27.5	394		1,297	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	81	27.5	81		260	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	142	27.5	142		444	10
11	INSTALL 667 SQ YARDS OF NYLON CARPET	2005	38,420	1,397	27.5	1,397		4,366	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS								13
14	ELECTRICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	601	27.5	601		1,876	14
15	REPLACE ROOF TOP UNIT - 1ST FLOOR DINING RM.	2005	9,842	358	27.5	358		1,119	15
16	F&I ELEVATOR SYSTEM CONTROLLER & TAPE	2006	14,875	541	27.5	541		1,600	16
17	ELCTRICAL PANEL & VENTILATORS OUTLET	2006	15,755	573	27.5	573		1,695	17
18	110 YARDS OF INTERFACE CARPET TILES IN ACTIVITY	2006	5,612	1,078	5	1,122	44	3,366	18
19	INSTALL HOT WATER LINE - KITCHEN TO LAUNDRY RM	2006	1,560	57	27.5	57		163	19
20	REPLACE BAD IGNITION MODULE, FLAME SENSORS								20
21	IGNITOR, GAS REGULATOR	2006	3,290	120	27.5	120		334	21
22	6 WOOD DOORS & 18 HINGE HARDWARE	2006	2,951	108	27.5	108		300	22
23	WALLCOVERING FOR 600, 700, 800 LOUNGES	2006	3,165	608	5	633	25	1,899	23
24	INSTALL ELECTRICAL WIRING FOR OFFICE A/C	2006	1,535	56	27.5	56		142	24
25	REPLACED WATER HEATER	2006	14,013	509	27.5	509		1,210	25
26	6 WOOD DOORS & 18 HINGE HARDWARE	2006	3,368	123	27.5	123		281	26
27	COUNTER TOPS FOR THERAPY ROOM	2007	714	26	27.5	26		50	27
28	INSTALL ELECTRICAL SUB PANELS IN CLOSET FOR CIRC	2007	8,555	311	27.5	311		596	28
29	WALLPAPER, TILES-1 & 2 FLR HALLWAYS & SHOWER RM	2007	115,000	4,182	27.5	4,182		7,667	29
30	FIRE DOOR	2007	1,932	70	27.5	70		129	30
31	INSTALLED VENDING MACHINE OUTLETS	2007	1,262	46	27.5	46		84	31
32	INSTALL MAIN EXHAUST FAN; REMODEL OF 8 SHOWER I	2007	22,000	800	27.5	800		1,400	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,254,109	\$ 144,278		\$ 214,719	\$ 70,441	\$ 3,452,027	34

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,254,109	\$ 144,278		\$ 214,719	\$ 70,441	\$ 3,452,027	1
2	CERAMIC TILE FOR BATHROOMS	2007	3,378	123	27.5	123		205	2
3	BONDING MORTAR, SAND MIX; OUTLET COVERS - 1 & 2 F	2007	4,952	180	27.5	180		300	3
4	PIPE SHOWER VALVE; ATTACH GRID ON FLR DRAIN	2007	5,164	187	27.5	187		297	4
5	COMPLETE ROOF WORK	2007	81,900	2,978	27.5	2,978		4,715	5
6	TILES FOR FLOOR & WALLS - SHOWER ROOMS	2007	9,883	359	27.5	359		539	6
7	PATCH/REPAIR VISIBLE CRACKS-ROOF AND 600-900 WING	2007	2,300	83	27.5	83		118	7
8	REPAIR HOT WATER LINE & REPLACE BATH RM VALVES	2007	1,751	64	27.5	64		85	8
9	MATERIALS FOR BATHROOM REMODEL	2007	9,451	344	27.5	344		430	9
10	PIPED IN 4 NEW SHOWER VALVES ALONG WITH BREAKER	2007	2,223	81	27.5	81		88	10
11	INSTALL 208 VOLT OUTLET IN KITCHEN	2007	882	32	27.5	32		35	11
12	INSTALL 2 SHOWER VALVES & REPIPED DRAIN	2007	1,195	43	27.5	43		47	12
13	REPLACE SOUTHWEST EXIT DOOR	2007	1,674	61	27.5	61		66	13
14	WALL COVERING, BORDERS, BLINDS, VALANCES FOR								14
15	1ST & 2ND FLR DINING RMS, RESIDENT ROOMS	2007	99,417	3,615	27.5	3,615		3,916	15
16	MATERIALS LIKE GROUT, TILE, GLOSS BISC, FLANGE								16
17	FOR BATHROOM REMODEL	2007	2,224	81	27.5	81		81	17
18	WALL PROTECTION SYSTEM FOR 1ST & 2ND FLOOR	2008	87,062	3,166	27.5	3,166		3,166	18
19	HVAC INSTALLATION	2008	3,800	138	27.5	138		138	19
20	2ND & 1ST FLOORS-WALLPAPER, BORDERS, TILES	2008	37,939	575	27.5	575		575	20
21	900 WING FLOOR & CEILING TILING, DRYWALL	2008	28,478	259	27.5	259		259	21
22	MOKE DOORS & THE HARDWARE FOR THE DOORS	2008	8,397	76	27.5	76		76	22
23	FURNISH & INSTALL ENCASED IN PVC FOR ELEVATOR	2008	19,985	484	27.5	484		484	23
24	ROOF REPLACEMENT	2008	165,800	2,010	27.5	2,010		2,010	24
25	NEW BREAKER, OUTLET IN KITCHEN & PIPING	2008	8,751	80	27.5	80		80	25
26	FIRST FLOOR-TILES IN SHOWER ROOM, WALLPAPERING	2008	122,851						26
27	FIRE PROTECTION SYSTEM UNDER CANOPY	2008	12,720	77	27.5	77		77	27
28	INSTALL THERO PANES IN LOUNGE AND CAFETERIA	2008	2,283	14	27.5	14		14	28
29	ALZHEIMERS ROOMS-BLINDS & BORDERS	2008	1,283	4	27.5	4		4	29
30									30
31			ADJ. TO SL	70,441			(70,441)		31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,979,852	\$ 229,833		\$ 229,833	\$	\$ 3,469,832	34

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

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

# **0040931**

Report Period Beginning:

**01/01/2008**

Ending:

**12/31/2008**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,296,231	\$ 108,293	\$ 113,021	\$ 4,728	3-15YRS	\$ 693,280	71
72	Current Year Purchases	215,454	129,272	10,773	(118,499)	3-15YRS	10,773	72
73	Fully Depreciated Assets	102,124					102,124	73
74	<b>RELATED PARTY</b>		6,315	6,315				74
75	<b>TOTALS</b>	\$ 1,613,809	\$ 243,880	\$ 130,109	\$ (113,771)		\$ 806,177	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 8,708,006	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 473,713	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 359,942	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (113,771)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,276,009	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: \$ 30,862 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	ADMINISTRATIVE	2008 FORD E350	\$ #####	\$ 17,106	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 17,106	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	\$		\$ 397,142	\$		\$ 397,142	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			133,217			133,217	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			628,412			628,412	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				238,104		238,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): <b>MEDICAL SUPPLIES</b>	39-12					131,687		131,687	13
14	<b>TOTAL</b>			\$		\$ 1,158,771	\$ 369,791		\$ 1,528,562	14

**NOTE:** This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 34,181	\$ 111,926	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 69,156 )	2,912,404	2,912,404	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,286	105,413	6
7	Other Prepaid Expenses	39,035	39,035	7
8	Accounts Receivable (owners or related parties)	880	3,085	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		226,963	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,054,786	\$ 3,398,826	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,883	1,883	12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		4,465,151	15
16	Equipment, at Historical Cost	1,613,809	1,613,809	16
17	Accumulated Depreciation (book methods)	(1,381,539)	(4,628,774)	17
18	Deferred Charges		38,420	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>	\$ 234,153	\$ 3,699,645	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,288,939	\$ 7,098,471	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,113,753	\$ 3,198,108	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	468,749	468,749	28
29	Short-Term Notes Payable	112,360	112,360	29
30	Accrued Salaries Payable	226,987	226,987	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,499	27,499	31
32	Accrued Real Estate Taxes(Sch.IX-B)		171,350	32
33	Accrued Interest Payable	2,681	23,221	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MANAGEMENT FEES</u>	794,705	794,705	36
37	<u>DUE TO LESSOR/PRIOR OWNER</u>	2,066,042	375,964	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,812,776	\$ 5,398,943	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,331,683	3,800,072	39
40	Mortgage Payable		4,564,400	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>	\$ 3,331,683	\$ 8,364,472	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 10,144,459	\$ 13,763,415	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (6,855,520)	\$ (6,664,944)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,288,939	\$ 7,098,471	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(4,534,116)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>	<b>1</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>(4,534,115)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(2,321,405)</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>(2,321,405)</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(6,855,520)</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	\$ 12,052,602	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,052,602	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>	\$	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	578	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>	\$ 578	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	885	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 885	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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,054,065	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,723,903	31
32	Health Care	5,154,895	32
33	General Administration	4,348,954	33
	<b>B. Capital Expense</b>		
34	Ownership	1,505,512	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,528,562	35
36	Provider Participation Fee	113,644	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,375,470	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,321,405)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,321,405)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	2,021	2,667	\$ 94,075	\$ 35.27	1
2	Assistant Director of Nursing	2,028	2,157	66,224	30.70	2
3	Registered Nurses	40,477	44,491	1,237,174	27.81	3
4	Licensed Practical Nurses	36,451	40,197	1,074,905	26.74	4
5	CNAs & Orderlies	119,890	128,231	1,743,821	13.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	675	881	12,399	14.07	8
9	Activity Director	3,639	4,329	64,699	14.95	9
10	Activity Assistants	6,424	6,907	65,565	9.49	10
11	Social Service Workers	5,560	6,181	111,783	18.08	11
12	Dietician					12
13	Food Service Supervisor	3,973	4,623	87,567	18.94	13
14	Head Cook	5,036	5,563	63,304	11.38	14
15	Cook Helpers/Assistants	22,230	23,215	201,914	8.70	15
16	Dishwashers					16
17	Maintenance Workers	2,018	2,163	50,656	23.42	17
18	Housekeepers	28,536	31,185	312,980	10.04	18
19	Laundry	3,496	4,155	45,919	11.05	19
20	Administrator	1,905	2,307	154,880	67.13	20
21	Assistant Administrator	1,994	2,155	50,389	23.38	21
22	Other Administrative					22
23	Office Manager	4,346	4,923	104,666	21.26	23
24	Clerical	10,840	11,803	177,304	15.02	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	4,334	4,486	126,114	28.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	305,873	332,619	\$ 5,846,338 *	\$ 17.58	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	347	\$ 23,445	1-3	35
36	Medical Director	96	13,500	9-3	36
37	Medical Records Consultant	32	1,536	10-3	37
38	Nurse Consultant	947	119,393	10-3	38
39	Pharmacist Consultant	96	2,400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	98	12,433	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	64	3,838	11-3	44
45	Social Service Consultant	109	11,037	12-3	45
46	Other(specify) <u>UTILIZATION REV</u>	27	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,816	\$ 192,082		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	86	\$ 4,187	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	86	\$ 4,187		53



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	2005	\$ 4,033	3	\$ 672	\$ 1,344	\$ 1,344	\$ 673	\$	\$	\$	\$													
2	PAINT/DECORATING	2006	1,961	3		326	654	654	327																
3																									
4																									
5																									
6																									
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15																									
16																									
17																									
18																									
19																									
20	<b>TOTALS</b>		\$ 5,994		\$ 672	\$ 1,670	\$ 1,998	\$ 1,327	\$ 327	\$	\$	\$													

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILL COUNCIL ON LTC-\$15173
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,835 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,644  
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? YES  
Attach invoices and a summary of services for all architect and appraisal fees