



Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632 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	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,251	2,251	8
9	SNF/PED					9
10	ICF	63,086	1,031		64,117	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,086	1,031	2,251	66,368	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.05%

D. How many bed-hold days during this year were paid by the Department? 1,801 (Do not include bed-hold days in Section B.)

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

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 11/1/90

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 2,243

Medicare Intermediary ADMINASTAR

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 HEALTHCARE CENTER** # **0036632** 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	198,564	27,614	12,135	238,313		238,313		238,313		1
2	Food Purchase		300,619		300,619	(22,893)	277,726	(846)	276,880		2
3	Housekeeping	189,691	45,538		235,229		235,229		235,229		3
4	Laundry	71,691	11,122		82,813		82,813		82,813		4
5	Heat and Other Utilities			179,017	179,017		179,017	131	179,148		5
6	Maintenance	94,750	31,981	50,813	177,544		177,544	22,443	199,987		6
7	Other (specify):*			24,609	24,609		24,609	55	24,664		7
8	<b>TOTAL General Services</b>	554,696	416,874	266,574	1,238,144	(22,893)	1,215,251	21,783	1,237,034		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,964,191	73,228	4,692	2,042,111		2,042,111	50,278	2,092,389		10
10a	Therapy	93,524	2,693	48,231	144,448		144,448	8,272	152,720		10a
11	Activities	104,902	25,523	816	131,241		131,241		131,241		11
12	Social Services	32,906			32,906		32,906		32,906		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,195,523	101,444	74,739	2,371,706		2,371,706	58,550	2,430,256		16
	<b>C. General Administration</b>										
17	Administrative	157,839		516,000	673,839		673,839	(353,613)	320,226		17
18	Directors Fees										18
19	Professional Services			371,975	371,975		371,975	(294,517)	77,458		19
20	Dues, Fees, Subscriptions & Promotions			12,582	12,582		12,582	(3,184)	9,398		20
21	Clerical & General Office Expenses	53,767	18,128	241,965	313,860		313,860	(66,844)	247,016		21
22	Employee Benefits & Payroll Taxes			359,042	359,042	22,893	381,935		381,935		22
23	Inservice Training & Education							2,957	2,957		23
24	Travel and Seminar			4,528	4,528		4,528	109	4,637		24
25	Other Admin. Staff Transportation			5,564	5,564		5,564	12,475	18,039		25
26	Insurance-Prop.Liab.Malpractice			249,403	249,403		249,403	3,397	252,800		26
27	Other (specify):*							76,712	76,712		27
28	<b>TOTAL General Administration</b>	211,606	18,128	1,761,059	1,990,793	22,893	2,013,686	(622,508)	1,391,178		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,961,825	536,446	2,102,372	5,600,643		5,600,643	(542,175)	5,058,468		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	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	9,390
	REPAIRS & MAINTENANCE	2,745
		0
		12,135
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	46,268
	ELECTRICITY	104,694
	WATER	27,238
	CABLE TV - LOBBY	817
		0
		179,017
6	<b>MAINTENANCE</b>	
	GROUND MAINTENANCE	11,594
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	28,683
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,195
	FIRE SERVICE	6,341
		0
		0
		0
		0
		50,813
7	<b>OTHER</b>	
	SCAVENGER	24,609
	SECURITY SERVICE	0
		0
		0
		24,609
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	21,000
		21,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	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	1,152
	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
		4,692
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	7,955
	SPEECH THERAPY SERVICES	189
	OCCUPATIONAL THERAPY SERVICES	2,155
	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
	<b>THERAPY CONTRACT SERVICES</b>	19,532
	<b>DENTAL SERVICE</b>	4,000
		48,231
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	816
		0
		816
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	<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
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	516,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	52,507
	ADMINISTRATIVE CONSULTANTS XIX C	282,000
	PROFESSIONAL FEES XIX C	37,468
		0
		371,975
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,812
	EMPLOYEE WANT ADS XIX F	900
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	2,834
	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	36
	PATIENT BACKGROUND CHECKS XIX F	0
		12,582
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,795
	EQUIPMENT REPAIR & MAINTENANCE	8,033
	OUTSIDE CLERICAL SERVICES	156,626
	PENALTIES / OVERDRAFT CHARGES VI 18	54,362
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	974
	TELEPHONE	17,626
	MESSENGER SERVICE	1,549
		0
		241,965

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	223,695
	UNEMPLOYMENT COMPENSATION XIX D	47,438
	WORKERS COMPENSATION INSURANC XIX D	57,304
	HOSPITALIZATION INSURANCE XIX D	24,160
	EMPLOYEE BENEFITS - OTHER XIX D	4,353
	EMPLOYEE PHYSICAL EXAMS XIX D	280
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	1,812
	CHICAGO HEAD TAX XIX D	0
		0
		359,042
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	4,528
	TRAVEL XIX G	0
		4,528
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	5,564
		5,564
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	249,403
		249,403
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

**2,102,372**

**COUNTRYSIDE HEALTHCARE CENTER  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	300,619
LESS SALES TAX	<u>(846)</u>
NET FOOD	299,773

TOTAL PATIENT CENSUS	66,368
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	199,104

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	16,470

PATIENT MEALS	199,104
ADD EMPLOYEE MEALS	<u>16,470</u>
TOTAL MEALS/YEAR	215,574

NET FOOD	299,773
DIVIDE TOTAL MEALS/YEAR	<u>215,574</u>

COST PER MEAL	1.39
TIME EMPLOYEE MEALS	<u>16,470</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>22,893</b>

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Facility Name &amp; ID Number

COUNTRYSIDE HEALTHCARE CENTER

#0036632

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			52,794	52,794		52,794	166,108	218,902			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,735	22,735		22,735	530,194	552,929			32
33	Real Estate Taxes			549,657	549,657		549,657	11,096	560,753			33
34	Rent-Facility & Grounds			675,375	675,375		675,375	(675,375)				34
35	Rent-Equipment & Vehicles			60,607	60,607		60,607	12,270	72,877			35
36	Other (specify):* OFFICE RENT			28,800	28,800		28,800	(28,800)				36
37	<b>TOTAL Ownership</b>			1,389,968	1,389,968		1,389,968	15,493	1,405,461			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,816	148,730	253,546		253,546		253,546			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,154	108,154		108,154		108,154			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		104,816	256,884	361,700		361,700		361,700			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,961,825	641,262	3,749,224	7,352,311		7,352,311	(526,682)	6,825,629			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	1,258	30		9
10	Interest and Other Investment Income	(49,486)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(846)	2		13
14	Non-Care Related Interest	(16,921)	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	(54,362)	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	(8,812)	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	(5,137)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (134,306)		\$	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)	(392,376)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (392,376)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (526,682)		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

STATE OF ILLINOIS  
 COUNTRYSIDE HEALTHCARE CENTER

ID# 0036632

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	STAFF TRANSPORTATION-MARKETING	(5,137)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,137)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(846)	0	0	0	0	0	0	0	0	0	0	(846)	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	131	0	0	0	0	0	0	0	0	131	5
6	Maintenance	0	0	22,443	0	0	0	0	0	0	0	0	22,443	6
7	Other (specify):*	0	0	55	0	0	0	0	0	0	0	0	55	7
8	<b>TOTAL General Services</b>	<b>(846)</b>	<b>0</b>	<b>22,629</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>21,783</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	50,278	0	0	0	0	0	0	0	0	50,278	10
10a	Therapy	0	0	8,249	23	0	0	0	0	0	0	0	8,272	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>58,527</b>	<b>23</b>	<b>0</b>	<b>58,550</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	0	(353,613)	0	0	0	0	0	0	0	0	(353,613)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(294,517)	0	0	0	0	0	0	0	0	(294,517)	19
20	Fees, Subscriptions & Promotions	(8,812)	0	5,628	0	0	0	0	0	0	0	0	(3,184)	20
21	Clerical & General Office Expenses	(54,362)	0	(12,482)	0	0	0	0	0	0	0	0	(66,844)	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	2,957	0	0	0	0	0	0	0	0	2,957	23
24	Travel and Seminar	0	0	109	0	0	0	0	0	0	0	0	109	24
25	Other Admin. Staff Transportation	(5,137)	0	17,612	0	0	0	0	0	0	0	0	12,475	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,397	0	0	0	0	0	0	0	0	3,397	26
27	Other (specify):*	0	0	76,712	0	0	0	0	0	0	0	0	76,712	27
28	<b>TOTAL General Administration</b>	<b>(68,311)</b>	<b>0</b>	<b>(554,197)</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>(622,508)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(69,157)</b>	<b>0</b>	<b>(473,041)</b>	<b>23</b>	<b>0</b>	<b>(542,175)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER # 0036632 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,258	151,669	0	13,181	0	0	0	0	0	0	0	166,108	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(66,407)	531,793	0	64,808	0	0	0	0	0	0	0	530,194	32
33	Real Estate Taxes	0	0	0	11,096	0	0	0	0	0	0	0	11,096	33
34	Rent-Facility & Grounds	0	(675,375)	0	0	0	0	0	0	0	0	0	(675,375)	34
35	Rent-Equipment & Vehicles	0	0	0	12,270	0	0	0	0	0	0	0	12,270	35
36	Other (specify):*	0	0	(28,800)	0	0	0	0	0	0	0	0	(28,800)	36
37	<b>TOTAL Ownership</b>	<b>(65,149)</b>	<b>8,087</b>	<b>(28,800)</b>	<b>101,355</b>	<b>0</b>	<b>15,493</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</b> (sum of lines 29, 37 & 44)	<b>(134,306)</b>	<b>8,087</b>	<b>(501,841)</b>	<b>101,378</b>	<b>0</b>	<b>(526,682)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				COUNTRYSIDE		
				H/C LLC	SKOKIE	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 675,375	COUNTRYSIDE HEALTHCARE CENTER, LLC		\$	(675,375)	1
2	V	30 SL DEPRECIATION		" "		147,798	147,798	2
3	V	32 INTEREST		" "		531,202	531,202	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V	30 SL DEPRESIATION		CAREPLUS REHABILITATIVE SERVICES		3,871	3,871	10
11	V	32 INTEREST		" "		591	591	11
12	V							12
13	V							13
14	Total		\$ 675,375			\$ 683,462	\$ * 8,087	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)
16	V	19 ADMIN. CONSULT. FEES	282,000	" "			(282,000)
17	V	19 DATA PROCESS FEES	36,660	" "			(36,660)
18	V	21 CLERICAL FEES	156,000	" "			(156,000)
19	V	36 OFFICE RENT	28,800	" "			(28,800)
20	V			" "			
21	V			" "			
22	V			" "			
23	V	5 UTILITIES		" "		131	131
24	V	6 MAINT AND REPAIR		" "		13,143	13,143
25	V	6 MAINTENANCE SALARIES		" "		9,300	9,300
26	V	7 SECURITY		" "		55	55
27	V	10 NURSING SALARIES		" "		50,278	50,278
28	V	10A THERAPY SALARIES		" "		8,249	8,249
29	V	17 ADMIN. SALARIES		" "		162,387	162,387
30	V	19 PROFESSIONAL FEES		" "		24,143	24,143
31	V	20 ADVERTISING		" "		5,628	5,628
32	V	21 TOTAL OFFICE		" "		31,976	31,976
33	V	21 CLERICAL SALARIES		" "		111,542	111,542
34	V	23 SEMINARS		" "		2,957	2,957
35	V	24 TRAVEL		" "		109	109
36	V	25 TRANSPORTATION		" "		17,612	17,612
37	V	26 INSURANCE		" "		3,397	3,397
38	V	27 EMPLOYEE BENEFITS		" "		76,712	76,712
39	Total		\$ 1,019,460			\$ 517,619	\$ * (501,841)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 DEPRECIATION (SL)	\$	CAREPLUS MGMT. INC.		\$ 13,181	\$	13,181	15
16	V	33 REAL ESTATE TAX-TAG 18 PPTY		" "		11,096		11,096	16
17	V	32 INTEREST		" "		60,536		60,536	17
18	V	32 INTEREST-TAG 18 PPTY-MTG		" "		3,883		3,883	18
19	V	32 INTEREST-CP REHAB-EQ LOAN		" "		389		389	19
20	V	35 EQUIPMENT RENT		" "		12,270		12,270	20
21	V	10A REHAB SUPPLIES		" "		23		23	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		\$			\$ 101,378	\$ *	101,378	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: 01/01/2008 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	<b>CAREPLUS MGMT ALLOCATIONS:</b>							\$		1	
2	<b>SHERWIN RAY</b>	<b>PRESIDENT</b>	<b>ADMINISTRATIVE</b>		<b>SEE ATTACHED</b>	<b>10.6</b>	<b>17.75</b>	<b>SALARY</b>	<b>34,612</b>	<b>17-7</b>	2
3			<b>FINANCE</b>		<b>SCHEDULE</b>						3
4	<b>JACOB BAKST</b>	<b>DIR OPERATIONS</b>	<b>ADMINISTRATIVE</b>			<b>10.6</b>	<b>17.75</b>	<b>SALARY</b>	<b>34,612</b>	<b>17-7</b>	4
5			<b>CONSULTING</b>								5
6	<b>ROSLYN INDICH</b>	<b>CLERICAL</b>	<b>CLERICAL</b>			<b>10.6</b>	<b>17.75</b>	<b>SALARY</b>	<b>10,789</b>	<b>17-7</b>	6
7											7
8											8
9											9
10											10
11											11
12											12
13								<b>TOTAL</b>	<b>\$ 80,013</b>		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:

01/01/2008

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 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	373,906	10	\$ 739	\$ 66,368	\$ 131	1
2	6	MAINT & REPAIRS	CENSUS DAYS	373,906	10	74,048	66,368	13,143	2
3	6	MAINTENANCE SALARIES	CENSUS DAYS	373,906	10	52,396	66,368	9,300	3
4	7	SECURITY	CENSUS DAYS	373,906	10	308	66,368	55	4
5	10	NURSING SALARIES	CENSUS DAYS	373,906	10	283,260	66,368	50,278	5
6	10A	THERAPY SALARIES	CENSUS DAYS	373,906	10	46,472	66,368	8,249	6
7	17	ADMIN. SALARIES	CENSUS DAYS	373,906	10	914,862	66,368	162,387	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	373,906	10	136,016	66,368	24,143	8
9	20	ADVERTISING	CENSUS DAYS	373,906	10	31,710	66,368	5,628	9
10	21	TOTAL OFFICE	CENSUS DAYS	373,906	10	180,149	66,368	31,976	10
11	21	CLERICAL SALARIES	CENSUS DAYS	373,906	10	628,409	66,368	111,542	11
12	23	SEMINARS	CENSUS DAYS	373,906	10	16,659	66,368	2,957	12
13	24	TRAVEL	CENSUS DAYS	373,906	10	612	66,368	109	13
14	25	TRANSPORTATION	CENSUS DAYS	373,906	10	99,225	66,368	17,612	14
15	26	INSURANCE	CENSUS DAYS	373,906	10	19,140	66,368	3,397	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	373,906	10	432,184	66,368	76,712	16
17	30	DEPRECIATION ( SL )	CENSUS DAYS	373,906	10	74,261	66,368	13,181	17
18	33	REAL ESTATE TAX	CENSUS DAYS	373,906	10	62,515	66,368	11,096	18
19	32	INTEREST	CENSUS DAYS	373,906	10	341,048	66,368	60,536	19
20	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	373,906	10	21,878	66,368	3,883	20
21	32	INTEREST-CP REHAB-EQ LOAN	CENSUS DAYS	373,906	10	2,189	66,368	389	21
22	35	EQUIPMENT RENT	CENSUS DAYS	373,906	10	69,127	66,368	12,270	22
23	10A	REHAB SUPPLIES	CENSUS DAYS	373,906	10	132	66,368	23	23
24									24
25	TOTALS				\$ 3,487,339	\$ 1,925,399		\$ 618,997	25

Facility Name & ID Number COUNTRYSIDE HEALTHCARE CENTER# 0036632

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 HEALTHCARE CENTER,LLC						\$	\$			\$	1						
2	LAKE FOREST BANK		X	MORTGAGE	\$55,766.87	2/9/06	8,000,000	7,611,172	2/9/09	6.7500	527,818	2						
3	LOAN FEES		X	LOAN FEES	W/O OVER LOAN		101,520	91,757			3,384	3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	CAREPLUS MANAGEMENT ALLOCATION										64,808	6						
7	A.I. CREDIT CORP.		X	INSURANCE FINANCING							5,814	7						
8	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS										591	8						
9	<b>TOTAL Facility Related</b>				\$55,766.87		\$ 8,101,520	\$ 7,702,929			\$ 602,415	9						
	<b>B. Non-Facility Related*</b>																	
10	IRS, IDR, ETC		X	LATE FEES							16,921	10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 16,921	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 8,101,520	\$ 7,702,929			\$ 619,336	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>484,809</b>	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.)		\$	<b>521,160</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>36,351</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>526,372</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ 13,067 For 2002 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(13,066)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>549,657</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>444,090</b>	8
	2004	<b>478,584</b>	9
	2005	<b>495,354</b>	10
	2006	<b>480,009</b>	11
	2007	<b>521,160</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2007 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:** 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 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 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>29-13-100-001-0000</u>	<u>NURSING HOME</u>	\$ <u>521,160.42</u>	\$ <u>521,160.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>521,160.42</u>	\$ <u>521,160.42</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 HEALTHCARE CENTER

# 0036632

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**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 HOM</u>	<u>132,928</u>	<u>1998</u>	<u>\$ 392,750</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>132,928</b>		<b>\$ 392,750</b>	<b>3</b>

Facility Name &amp; ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

Report Period Beginning:

01/01/2008 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	197	1998		\$ 5,408,525	\$ 138,675	39	\$ 138,675	\$	\$ 1,473,557	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1991	24,648	782	31.5	782		13,963	9
10	LEASEHOLD IMPROVEMENTS		1992	28,172	894	31.5	894		14,797	10
11	LEASEHOLD IMPROVEMENTS		1993	11,940	337	31.5	337		5,580	11
12	LEASEHOLD IMPROVEMENTS		1994	4,878	125	39	125		1,794	12
13	TILE / ROOF VENTS		1995	16,191	416	39	416		5,621	13
14	WALL / WATER PANEL		1995	4,199	107	39	107		1,429	14
15	LANDSCAPING/PARKING LOT REPAIRS		1995	13,614	908	15	908		12,257	15
16	ROOF REPAIRS		1996	13,369	342	39	342		4,325	16
17	SINK		1996	683	18	39	18		225	17
18	ROOF-TOP A/C UNIT		1996	5,100	131	39	131		1,599	18
19	WINDOWS		1996	1,080	28	39	28		339	19
20	WINDOWS		1997	14,040	360	39	360		4,153	20
21	WALK-IN FREEZER		1997	3,196	82	39	82		933	21
22	WINDOWS		1998	8,370	214	39	214		2,288	22
23	FLOORING / TILE / CARPETING		1998	3,396	87	39	87		927	23
24	CEILING TILES		1998	2,213	57	39	57		582	24
25	ROOF REPAIRS / ROOFTOP A/C		1999	33,838	868	39	868		8,137	25
26	ROOF REPAIRS		2000	13,505	346	39	346		3,071	26
27	INSTALLATION CORNICES & SHEERS		2000	3,280	119	27.5	119		1,017	27
28	DRAPERY PANELS		2000	2,170		20	109	109	981	28
29	CARPETING OFFICES		2001	1,814		20	91	91	728	29
30	INSTALLED ROOF TOP UNIT		2001	6,992	254	27.5	254		1,789	30
31	LOBBY, NURSES STATION, HALLWAY-FLOORING,CEILING		2003	100,619	3,659	27.5	3,659		20,887	31
32	REMOVAL AND REINSTALLATION OF CUBICLE TRACKS		2003	4,501	259	20	225	(34)	1,350	32
33	REPLACE FIRE ALARM SYSTEM		2003	5,204	189	27.5	189		1,000	33
34	NEW DURO-LAST ROOFING SYSTEM		2003	28,100	1,022	27.5	1,022		5,153	34
35	PAINTING		2004	4,100	472	20	205	(267)	1,025	35
36	BATHROOMS AND OFFICE REMODELING		2004	43,350	1,576	27.5	1,576		6,370	36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

Report Period Beginning:

01/01/2008 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	REPLACED FRONT DOOR	2004	\$ 2,164	\$ 79	27.5	\$ 79	\$	\$ 372	37
38	REPLACEMENT OF DECK PANELS	2005	74,108	2,695	27.5	2,695		10,668	38
39	INSTALLED DELAYED EGRESS	2005	6,875	250	27.5	250		969	39
40	VARIOUS WALKS	2006	5,000	333	15	333		999	40
41	INSTALLED EXHAUST FAN & SMOKE DAMPERS	2006	12,132	441	27.5	441		1,084	41
42	TUCKPOINTING	2006	4,850	177	27.5	177		435	42
43	FLOORING RESIDENT & BATHROOMS	2006	43,156	1,569	27.5	1,569		3,857	43
44	PARKING LOT IMPROVEMENTS-ASPHALT	2007	20,500	1,367	15	1,367		2,392	44
45	CUBICLE CURTAINS-RESIDENT ROOMS & BATHROOMS	2007	13,978	4,473	5	4,473		7,269	45
46	INSTALL CORRIDOR DOORS, HINGES & CLOSERS	2007	3,420	124	27.5	124		171	46
47	INSTALL NEW AIR CONDITION UNIT-COMPUTER ROOM	2007	2,531	810	5	810		1,316	47
48	REPLACE FEDDER ROOF TOP UNIT IN DINNING ROOM	2007	5,739	209	27.5	209		287	48
49	REPLACED SCHOWER STALLS IN THE A-B WING	2008	3,714	107	27.5	107		107	49
50	INSTALLATION OF ANTI-FREEZE LOOP	2008	7,995	84	27.5	84		84	50
51	INSTALLATION OF FIRE ALARM DEVICES	2008	4,500	48	27.5	48		48	51
52	INSTALLED GENERATOR & TRANSFER SWITCH	2008	53,752	81	27.5	81		81	52
53	INSTALLED NEW FURNACE IN THE A-B WING	2008	4,125	229	15	229		229	53
54									54
55									55
56									56
57									57
58									58
59	RELATED PARTY ALLOCATION:								59
60	COUNTRYSIDE HEALTHCARE CENTER LLC								60
61	ROOF	2001	255,225	9,123	27.5	9,123			61
62									62
63									63
64	CAREPLUS MGMT								64
65	BUILDING-TAG-18 PROPERTIES	2004	69,195	2,776	39	2,776			65
66	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	27,184	2,099	39	2,099			66
67	BUILDING IMPROVEMENTS-CAREPLUS MGMT	2007		11	39	11			67
68	CAREPLUS REHAB								68
69	ROOF VENTILATOR	2003	1,967	50	39		(50)		69
70	TOTAL (lines 4 thru 69)		\$ 6,433,197	\$ 179,462		\$ 179,311	\$ (151)	\$ 1,626,245	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	\$ 276,791	\$ 10,923	\$ 24,047	\$ 13,124	3-15	\$ 184,065	71
72	Current Year Purchases	21,861	13,117	1,402	(11,715)	5-10	1,402	72
73	Fully Depreciated Assets	118,132					118,132	73
74	<b>RELATED PARTY SL DEPRECIATION</b>		12,116	12,116				74
75	<b>TOTALS</b>	\$ 416,784	\$ 36,156	\$ 37,565	\$ 1,409		\$ 303,599	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	<b>FACILITY</b>	<b>DODGE RAM BR 150</b>	<b>2006</b>	\$ 10,132	\$ 2,026	\$ 2,026	\$	5	\$ 6,078	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 10,132	\$ 2,026	\$ 2,026	\$		\$ 6,078	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)	\$ 7,252,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 217,644	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,902	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,258	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,935,922	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: \$ 52,358 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		\$ <u>687.44</u>	\$ <u>8,249</u>	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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	\$		\$ 77,009	\$		\$ 77,009	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			189			189	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			71,532			71,532	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				104,816		104,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 148,730	\$ 104,816		\$ 253,546	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: 01/01/2008

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	\$ 11,818	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,635 )	3,902,387		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	160,137		6
7	Other Prepaid Expenses	13,993		7
8	Accounts Receivable (owners or related parties)	2,961,423		8
9	Other(specify): Real Estate Tax Escrow	180,844		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 7,230,602	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	671,100		15
16	Equipment, at Historical Cost	426,916		16
17	Accumulated Depreciation (book methods)	(560,284)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 537,732	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,768,334	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 845,124	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,224		28
29	Short-Term Notes Payable	1,673,494		29
30	Accrued Salaries Payable	210,295		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,897		31
32	Accrued Real Estate Taxes(Sch.IX-B)	526,372		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,363,406	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,363,406	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,404,928	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,768,334	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,983,831</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>4</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>2,983,835</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,421,093</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>1,421,093</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>4,404,928</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	\$ 8,722,657	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,722,657	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,261	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,261	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	49,486	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 49,486	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>	\$ 8,773,404	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,238,144	31
32	Health Care	2,371,706	32
33	General Administration	1,990,793	33
	<b>B. Capital Expense</b>		
34	Ownership	1,389,968	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	253,546	35
36	Provider Participation Fee	108,154	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,352,311	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,421,093	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,421,093	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: **01/01/2008**

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	2,147	2,358	\$ 85,398	\$ 36.22	1
2	Assistant Director of Nursing	1,622	1,925	63,290	32.88	2
3	Registered Nurses	7,079	7,407	192,814	26.03	3
4	Licensed Practical Nurses	30,196	31,331	692,329	22.10	4
5	CNAs & Orderlies	57,238	63,408	533,302	8.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,876	6,497	93,524	14.39	8
9	Activity Director	2,033	2,164	29,171	13.48	9
10	Activity Assistants	8,781	9,308	75,731	8.14	10
11	Social Service Workers	2,029	2,094	32,906	15.71	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,151	36,650	17.04	13
14	Head Cook	6,341	7,048	68,488	9.72	14
15	Cook Helpers/Assistants	10,658	11,761	93,426	7.94	15
16	Dishwashers					16
17	Maintenance Workers	8,398	8,660	94,750	10.94	17
18	Housekeepers	20,412	22,700	189,691	8.36	18
19	Laundry	7,948	8,947	71,691	8.01	19
20	Administrator	2,059	2,208	106,597	48.28	20
21	Assistant Administrator	1,952	2,110	51,242	24.29	21
22	Other Administrative					22
23	Office Manager	2,798	2,926	23,045	7.88	23
24	Clerical	1,971	2,101	30,722	14.62	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	1,568	1,775	18,274	10.30	31
32	Other Health Care(specify)	20,161	21,238	378,784	17.84	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,249	220,117	\$ 2,961,825 *	\$ 13.46	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	\$ 9,390	1-3	35
36	Medical Director	O	21,000	9-3	36
37	Medical Records Consultant	N	1,152	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	816	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)		\$ 50,298		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	\$ 106,597	Workers' Compensation Insurance	\$ 57,304	IDPH License Fee	\$ 1,990	
WILLIE WILSON	ASST ADMIN	0	51,242	Unemployment Compensation Insurance	47,438	Advertising: Employee Recruitment	900	
				FICA Taxes	223,695	Health Care Worker Background Check	36	
				Employee Health Insurance	24,160	(Indicate # of checks performed <u>125</u> )		
				Employee Meals	22,893	Patient Background Checks	134	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	4,353	MARKETING/ADV/PROMO	8,812	
				EMPLOYEE PHYSICAL EXAMS	280	LICENSES/DUES/SUBSCRIPTIONS	844	
				PENSION/PROFIT SHARING PLANS	1,812	MGMT CO ALLOC	5,628	
				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	(8,812)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 157,839	TOTAL (agree to Schedule V, line 22, col.8)	\$ 381,935	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,398	
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	
							MGMT CO ALLOC	109
							Seminar Expense	4,528
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 516,000	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,637
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE ATTACHED SCHEDULE								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 371,975					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number COUNTRYSIDE HEALTHCARE CENTER

# 0036632

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (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? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 1,844 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. \$ 108,154  
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. \$ 22,893 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