

Facility Name & ID Number Country Health

0007880 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	10,502	10,350	1,703	22,555	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	10,502	10,350	1,703	22,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.43%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1970

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 1,703

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	221,461	10,449		231,910		231,910		231,910		1
2	Food Purchase		146,369		146,369		146,369		146,369		2
3	Housekeeping	102,035	13,204		115,239		115,239		115,239		3
4	Laundry	42,991	11,835		54,826		54,826		54,826		4
5	Heat and Other Utilities			88,534	88,534		88,534		88,534		5
6	Maintenance	33,536	50,390	39,543	123,469		123,469		123,469		6
7	Other (specify):*										7
8	TOTAL General Services	400,023	232,247	128,077	760,347		760,347		760,347		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,220,542	95,685	12,253	1,328,480		1,328,480		1,328,480		10
10a	Therapy		97,452	261,795	359,247	(136,929)	222,318		222,318		10a
11	Activities	81,217	4,199		85,416		85,416		85,416		11
12	Social Services	42,249		3,178	45,427		45,427		45,427		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,344,008	197,336	289,226	1,830,570	(136,929)	1,693,641		1,693,641		16
	C. General Administration										
17	Administrative	85,103			85,103		85,103		85,103		17
18	Directors Fees										18
19	Professional Services			136,401	136,401		136,401	(1,251)	135,150		19
20	Dues, Fees, Subscriptions & Promotions			60,412	60,412	(48,728)	11,684	(2,129)	9,555		20
21	Clerical & General Office Expenses	132,215	26,028	4,578	162,821		162,821		162,821		21
22	Employee Benefits & Payroll Taxes			369,458	369,458		369,458		369,458		22
23	Inservice Training & Education			3,335	3,335		3,335		3,335		23
24	Travel and Seminar			1,211	1,211		1,211		1,211		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			111,709	111,709		111,709		111,709		26
27	Other (specify):*										27
28	TOTAL General Administration	217,318	26,028	687,104	930,450	(48,728)	881,722	(3,380)	878,342		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,961,349	455,611	1,104,407	3,521,367	(185,657)	3,335,710	(3,380)	3,332,330		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.

Facility Name & ID Number

Country Health

#0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			107,086	107,086		107,086		107,086			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,426	12,426		12,426		12,426			35
36	Other (specify):*											36
37	TOTAL Ownership			119,512	119,512		119,512		119,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					136,929	136,929		136,929			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					185,657	185,657		185,657			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,961,349	455,611	1,223,919	3,640,879		3,640,879	(3,380)	3,637,499			45

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

Country Health

ID# 0007880

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,251)	19	22
23				23
24		0	27	24
25		(2,129)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,380)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Country Health# 0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,251)	0	0	0	0	0	0	0	0	0	0	(1,251)	19
20	Fees, Subscriptions & Promotions	(2,129)	0	0	0	0	0	0	0	0	0	0	(2,129)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,380)	0	(3,380)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,380)	0	(3,380)	29									

STATE OF ILLINOIS

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,380)	0	0	0	0	0	0	0	0	0	0	(3,380)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V				0.00%			2
3	V							3
4	V				0.00%			4
5	V							5
6	V				0.00%			6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$		0.00%	\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* 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		\$		0.00%	\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

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	Attached list of Board								\$		1
2											2
3									0	line 18	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 Country Health # 0007880 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Country Health

0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10	Interest Income																	
11	Allocated Corporate																	
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior brick Frame wood 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).

NONE

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>27,031</u>	1
2					2
3	TOTALS			\$ <u>27,031</u>	3

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	89				\$ 744,720	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976 Improvements		1976		10,703						9
10	1977 Improvements		1979		15,361						10
11	1978 Improvements		1977		25,766						11
12	1979 Improvements		1978		6,618						12
13	1980 Improvements		1980		30,846						13
14	1981 Improvements		1981		18,567						14
15	1982 Improvements		1982		4,662						15
16	1983 Improvements		1983		28,833						16
17	1984 Improvements		1984		6,700						17
18	1985 Improvements		1985		33,953						18
19	1986 Improvements		1986		23,775						19
20	1987 Improvements		1987		40,603						20
21	1988 Improvements		1988		163,565						21
22	1989 Improvements		1989		50,581						22
23	1990 Improvements		1990		111,695						23
24	1991 Improvements		1991		36,516						24
25	1992 Improvements		1992		26,816						25
26	1993 Improvements		1993		21,383						26
27	1994 Improvements		1994		12,384						27
28	1995 Improvements		1995		5,450						28
29	NURSE CALL SYSTEM		1996		6,349						29
30	DINNING ROOM EXPANSION		1996		10,109						30
31	Dinning Room Remodel		1997		6,121						31
32											32
33											33
34	C/O Allocation					66,997		66,997		1,505,179	34
35	Book Depreciation										35
36											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 & ID Number Country Health

0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	Dinning Room Remodel	1998	\$ 212,044	\$		\$	\$	\$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,891,513	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	70

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,891,513	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19	Parking Lot Paving	2004	18,500						19
20	Door Locks	2004	5,992						20
21	Resident Room Remodel--Paint, flooring, drapes	2004	24,239						21
22	ansul system	2004	1,614						22
23	Board Room Remodel -- Paint	2004	1,550						23
24	Garage Door	2004	750						24
25	Door Alarm System	2004	10,861						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,017,721	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,017,721	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	1
2									2
3	Resident Room Remodel-- Flooring, paint	2005	696						3
4	Door Alarm	2005	9,840						4
5	Board Room Remodel -- Paint	2005	741						5
6	Activity Room Remodel -- Paint, Flooring	2005	5,359						6
7	Employee Breakroom Remodel -- Paint	2005	1,182						7
8	Chiller	2005	46,799						8
9	Lobby Remodel -- Paint, Flooring	2005	23,981						9
10	Water valves	2005	24,320						10
11	Roof	2005	6,056						11
12	Nurse Call Station	2005	640						12
13	A/C Units	2005	5,127						13
14	Exterior Rehab	2005	1,172						14
15	Parking Lot Resurface	2005	1,449						15
16	CCTV Monitor and Camera	2005	2,407						16
17	Safety Control --Boiler	2005	1,180						17
18	Landscaping	2005	683						18
19	Dining Room Painting	2005	2,375						19
20	Flooring	2005	1,419						20
21									21
22	Dining Room Painting	2006	4,228						22
23	Landscaping	2006	1,411						23
24	Sewage Grinder	2006	18,519						24
25	Sidewalk	2006	1,997						25
26	Fire Door	2006	1,401						26
27	Resident Room Remodel-- Flooring, paint	2006	6,850						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,187,553	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,187,553	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	1
2									2
3	1/2 hp Auto Door Opener	2007	750						3
4	Water Heater	2007	6,517						4
5	Roof Repair	2007	851						5
6	Water Main	2007	1,462						6
7	Fire System	2007	1,662						7
8	Boiler	2007	1,044						8
9	Breakers	2007	1,393						9
10	Water Softener	2007	1,382						10
11									11
12	HVAC Units	2008	3,627						12
13	Mixing Valve	2008	8,834						13
14	Circulator Pump	2008	2,869						14
15									15
16	Water Heater	2009	2,860						16
17	Fire Door	2009	4,245						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	TOTAL (lines 1 thru 33)		\$ 2,225,049	\$ 66,997		\$ 66,997	\$	\$ 1,505,179	34

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

Facility Name & ID Number Country Health

0007880

Report Period Beginning:

01/01/2009

Ending:

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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	\$ 910,116	\$ 39,898	\$ 39,898	\$		\$ 946,464	71
72	Current Year Purchases	9,026						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 919,142	\$ 39,898	\$ 39,898	\$		\$ 946,464	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		2008 Chevy Van	2005	\$ 39,380	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 39,380	\$	\$	\$		\$	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)	\$ 3,210,602	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,895	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,895	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,451,643	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	Walnut Apartments	\$ 599,918	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 599,918	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	New Wing & remodel	\$ 3,150,965	92
93			93
94			94
95		\$ 3,150,965	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: _____

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: \$ 12,426 Description: _____
(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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 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>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 101,919	\$		\$ 101,919	1
2	Licensed Speech and Language Development Therapist		hrs			8,896			8,896	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			111,360	143		111,503	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				97,309		97,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					39,620			39,620	13
14	TOTAL			\$		\$ 261,795	\$ 97,452		\$ 359,247	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 Country Health# 0007880Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,363,647	\$	1
2	Cash-Patient Deposits	9,983		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	404,228		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,467		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,286		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,820,611	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	130,783		13
14	Buildings, at Historical Cost	2,148,510		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	946,464		16
17	Accumulated Depreciation (book methods)	(2,454,146)		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): <u>CIP</u>	3,150,965		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,922,576	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,743,187	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 279,804	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,983		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,453		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,838		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 431,078	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,263,640		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,263,640	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,694,718	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,048,469	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,743,187	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,920,342	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,920,342	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	128,127	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 128,127	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,048,469	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Country Health

0007880

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,663,306	1
2	Discounts and Allowances for all Levels	(1,026,242)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,637,064	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	895,065	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 895,065	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,811	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,833	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 182,644	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,041	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,041	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	29,192	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,192	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,769,006	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	760,347	31
32	Health Care	1,830,570	32
33	General Administration	930,450	33
B. Capital Expense			
34	Ownership	119,512	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Non Nursing Home Income		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,640,879	40
41	Income before Income Taxes (line 30 minus line 40)**	128,127	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 128,127	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** 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 Country Health

0007880

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	2,044	2,144	\$ 55,551	\$ 25.91	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,650	9,423	230,379	24.45	3
4	Licensed Practical Nurses	10,984	11,987	228,286	19.04	4
5	CNAs & Orderlies	45,957	50,736	655,256	12.92	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,339	3,692	51,070	13.83	8
9	Activity Director					9
10	Activity Assistants	5,873	7,435	81,217	10.92	10
11	Social Service Workers	3,157	3,367	42,249	12.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,550	21,532	221,461	10.29	15
16	Dishwashers					16
17	Maintenance Workers	3,435	3,730	33,536	8.99	17
18	Housekeepers	8,240	8,965	102,035	11.38	18
19	Laundry	4,395	4,899	42,991	8.78	19
20	Administrator	1,900	2,080	85,103	40.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,810	7,597	132,215	17.40	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,334	137,587	\$ 1,961,349 *	\$ 14.26	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	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,480		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,670		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,178		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,328		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	104	\$ 4,142	50
51	Licensed Practical Nurses	73	2,560	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)	177	\$ 6,702	53

Facility Name & ID Number Country Health

0007880

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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? yes
If YES, give association name and amount. Illinois Health Care Association
- (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? _____
- (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? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (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 xx 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. \$ 48,728
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? yes Indicate the amount. \$ 7,426
- (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? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb
- (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.