



Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 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 01/01/2009

	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	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,083	1,924	7,912	18,919	8
9	SNF/PED					9
10	ICF	37,640	7,971	3,888	49,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,723	9,895	11,800	68,418	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

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 07/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number

of beds certified 127 and days of care provided 6,974

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICES)

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name &amp; ID Number

COUNTRYSIDE CARE CENTRE

# 0040931

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
	<b>A. General Services</b>										
1	Dietary	352,598	53,371	26,389	432,358		432,358	(823)	431,535		1
2	Food Purchase		343,154		343,154		343,154	(3,432)	339,722		2
3	Housekeeping	300,007	68,743		368,750		368,750	12,352	381,102		3
4	Laundry	28,916	56,617	5,043	90,576		90,576	2,799	93,375		4
5	Heat and Other Utilities			277,331	277,331		277,331		277,331		5
6	Maintenance	52,771	77,318	60,140	190,229		190,229	(497)	189,732		6
7	Other (specify):*			56,617	56,617		56,617		56,617		7
8	<b>TOTAL General Services</b>	734,292	599,203	425,520	1,759,015		1,759,015	10,399	1,769,414		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	3,939,842	254,166	122,561	4,316,569		4,316,569	(45,757)	4,270,812		10
10a	Therapy	127,071		271	127,342		127,342		127,342		10a
11	Activities	125,342	9,537	20,972	155,851		155,851	(5,046)	150,805		11
12	Social Services	94,514		14,251	108,765		108,765		108,765		12
13	CNA Training										13
14	Program Transportation			1,331	1,331		1,331		1,331		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,286,769	263,703	168,386	4,718,858		4,718,858	(50,803)	4,668,055		16
	<b>C. General Administration</b>										
17	Administrative	214,728		531,254	745,982		745,982	(528,259)	217,723		17
18	Directors Fees										18
19	Professional Services			448,976	448,976		448,976	(136,430)	312,546		19
20	Dues, Fees, Subscriptions & Promotions			201,070	201,070		201,070	(153,323)	47,747		20
21	Clerical & General Office Expenses	241,026	57,391	60,764	359,181		359,181	256,881	616,062		21
22	Employee Benefits & Payroll Taxes			1,009,317	1,009,317		1,009,317		1,009,317		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,163	9,163		9,163	16,655	25,818		24
25	Other Admin. Staff Transportation			8,791	8,791		8,791		8,791		25
26	Insurance-Prop.Liab.Malpractice			376,126	376,126		376,126	7,350	383,476		26
27	Other (specify):*			225,846	225,846		225,846	(225,846)			27
28	<b>TOTAL General Administration</b>	455,754	57,391	2,871,307	3,384,452		3,384,452	(762,972)	2,621,480		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,476,815	920,297	3,465,213	9,862,325		9,862,325	(803,376)	9,058,949		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	20,266
	REPAIRS & MAINTENANCE	6,123
		0
		26,389
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	5,043
		0
		5,043
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	94,008
	ELECTRICITY	84,876
	WATER	98,447
	CABLE TV - LOBBY	0
		0
		277,331
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	32,592
	PAINTING & DECORATING	1,219
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,231
	ELEVATOR MAINTENANCE & REPAIR	6,952
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,790
	FIRE SERVICE	6,356
		0
		0
		0
		0
		60,140
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	51,270
	SECURITY SERVICE	5,347
		0
		0
		56,617
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,000
		9,000

LINE	SCHED REF	TOTAL
<b>10</b>	<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	968
	PHARMACY CONSULTANT XVIII B 39-2	2,200
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	119,393
		0
		0
		122,561
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	271
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		271
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	17,918
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,054
		0
		20,972
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	12,875
	SOCIAL WORKER XVIII B 45-2	1,376
		0
		14,251
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,331
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	531,254
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	20,403
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	428,573
		0
		448,976
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	111,819
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	9,784
	EMPLOYEE WANT ADS XIX F	27,620
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	11,505
	LICENSES & PERMITS XIX F	2,610
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	25,377
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	7,395
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,190
	PATIENT BACKGROUND CHECKS XIX F	3,770
		201,070
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,119
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	10,853
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	43,430
	MESSENGER SERVICE	4,362
		0
		60,764

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	410,363
	UNEMPLOYMENT COMPENSATION XIX D	39,142
	WORKERS COMPENSATION INSURANCE XIX D	104,780
	HOSPITALIZATION INSURANCE XIX D	419,363
	EMPLOYEE BENEFITS - OTHER XIX D	15,592
	EMPLOYEE PHYSICAL EXAMS XIX D	5,980
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	14,097
	CHICAGO HEAD TAX XIX D	0
		0
		1,009,317
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	8,664
	TRAVEL XIX G	499
		9,163
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	8,791
		8,791
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	376,126
		376,126
27	<b>OTHER</b>	
	BAD DEBTS VI 24	225,846
		225,846

GRAND TOTAL COLUMN 3 OTHER **3,465,213**

**COUNTRYSIDE CARE CENTRE  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	343,154
LESS SALES TAX	<u>(3,432)</u>
NET FOOD	339,722

TOTAL PATIENT CENSUS	68,418
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	205,254

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

PATIENT MEALS	205,254
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	205,254

NET FOOD	339,722
DIVIDE TOTAL MEALS/YEAR	<u>205,254</u>

COST PER MEAL	1.66
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

COUNTRYSIDE CARE CENTRE

#0040931

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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			247,683	247,683		247,683	139,180	386,863			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,807	48,807		48,807	213,901	262,708			32
33	Real Estate Taxes			226,004	226,004		226,004		226,004			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(707,378)	55,472			34
35	Rent-Equipment & Vehicles			42,678	42,678		42,678	14,607	57,285			35
36	Other (specify):* MTG INSURANCE							22,654	22,654			36
37	<b>TOTAL Ownership</b>			1,328,022	1,328,022		1,328,022	(317,036)	1,010,986			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		356,445	1,216,797	1,573,242		1,573,242		1,573,242			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		356,445	1,327,940	1,684,385		1,684,385		1,684,385			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	5,476,815	1,276,742	6,121,175	12,874,732		12,874,732	(1,120,412)	11,754,320			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	(106,687)	30		9
10	Interest and Other Investment Income	(32,171)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,432)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,853)	21		18
19	Entertainment	(111,819)	20		19
20	Contributions	(7,395)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(15,355)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(225,846)	27		24
25	Fund Raising, Advertising and Promotional	(9,784)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(25,377)	20		28
29	Other-Attach Schedule	7,085			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (541,634)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(578,778)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (578,778)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (1,120,412)		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.**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0040931

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 327	6	1
2	VACATION ACCRUAL	(823)	1	2
3	VACATION ACCRUAL	12,352	3	3
4	VACATION ACCRUAL	2,799	4	4
5	VACATION ACCRUAL	(824)	6	5
6	VACATION ACCRUAL	(5,039)	10	6
7	VACATION ACCRUAL	(5,046)	11	7
8	VACATION ACCRUAL	2,995	17	8
9	VACATION ACCRUAL	3,505	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(1)	19	11
12	MARKETING CONSULATANT	(1,160)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	7,085		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

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	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	(823)	0	0	0	0	0	0	0	0	0	0	(823)	1
2	Food Purchase	(3,432)	0	0	0	0	0	0	0	0	0	0	(3,432)	2
3	Housekeeping	12,352	0	0	0	0	0	0	0	0	0	0	12,352	3
4	Laundry	2,799	0	0	0	0	0	0	0	0	0	0	2,799	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(497)	0	0	0	0	0	0	0	0	0	0	(497)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>10,399</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>10,399</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	(5,039)	0	0	(40,718)	0	0	0	0	0	0	0	(45,757)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,046)	0	0	0	0	0	0	0	0	0	0	(5,046)	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>(10,085)</b>	<b>0</b>	<b>0</b>	<b>(40,718)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,803)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	2,995	0	(265,627)	0	0	(265,627)	0	0	0	0	0	(528,259)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,516)	12,820	159,610	1,203	(291,547)	0	0	0	0	0	0	(136,430)	19
20	Fees, Subscriptions & Promotions	(154,375)	0	229	75	748	0	0	0	0	0	0	(153,323)	20
21	Clerical & General Office Expenses	(7,348)	0	12,961	2,678	248,590	0	0	0	0	0	0	256,881	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	4,019	5,321	7,315	0	0	0	0	0	0	16,655	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	1,725	2,344	3,281	0	0	0	0	0	0	7,350	26
27	Other (specify):*	(225,846)	0	0	0	0	0	0	0	0	0	0	(225,846)	27
28	<b>TOTAL General Administration</b>	<b>(403,090)</b>	<b>12,820</b>	<b>(87,083)</b>	<b>11,621</b>	<b>(31,613)</b>	<b>(265,627)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(762,972)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(402,776)</b>	<b>12,820</b>	<b>(87,083)</b>	<b>(29,097)</b>	<b>(31,613)</b>	<b>(265,627)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(803,376)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

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

	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)	
	<b>D. Ownership</b>													
30	Depreciation	(106,687)	238,841	1,290	460	5,276	0	0	0	0	0	0	139,180	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,171)	246,072	0	0	0	0	0	0	0	0	0	213,901	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	0	2,028	53,444	0	0	0	0	0	0	(707,378)	34
35	Rent-Equipment & Vehicles	0	0	6,815	6,104	1,688	0	0	0	0	0	0	14,607	35
36	Other (specify):*	0	22,654	0	0	0	0	0	0	0	0	0	22,654	36
37	<b>TOTAL Ownership</b>	<b>(138,858)</b>	<b>(255,283)</b>	<b>8,105</b>	<b>8,592</b>	<b>60,408</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(317,036)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(541,634)</b>	<b>(242,463)</b>	<b>(78,978)</b>	<b>(20,505)</b>	<b>28,795</b>	<b>(265,627)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,120,412)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 762,850	COUNTRYSIDE HEALTH CARE CENTRE		\$	\$ (762,850)	1
2	V	36 MORTGAGE INSURANCE		" "		22,654	22,654	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		238,841	238,841	3
4	V	30 DEPRECIATION - EQPT /FURN		" "				4
5	V	32 AMORTIZATION - MTG COST		" "		1,283	1,283	5
6	V	32 INTEREST - MORTGAGE		" "		244,789	244,789	6
7	V	32 INTEREST - OTHER		" "				7
8	V	19 ACCOUNTING FEES		" "		12,570	12,570	8
9	V	19 DATA PROCESSING		" "		150	150	9
10	V	19 LEGAL FEES		" "				10
11	V	19 OTHER PROFESSIONAL		" "		100	100	11
12	V							12
13	V							13
14	Total		\$ 762,850			\$ 520,387	\$ * (242,463)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 159,610	\$ 159,610	15
16	V	20	DUES & SUBSCRIPTIONS		" "		229	229	16
17	V	21	CLERICAL		" "		12,961	12,961	17
18	V	24	TRAVEL		" "		4,019	4,019	18
19	V	26	INSURANCE		" "		1,725	1,725	19
20	V	35	RENT - EQPT & VEHICLE		" "		6,815	6,815	20
21	V	17	ADMINISTRATIVE	265,627	" "			(265,627)	21
22	V	30	DEPRECIATION		" "		1,290	1,290	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			\$ 265,627			\$ 186,649	\$ * (78,978)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 119,393	CARLYLE NURSING ASSOCIATES, LLC		\$ 78,675	\$ (40,718)
16	V	19 PROFESSIONAL FEES		" "		1,203	1,203
17	V	20 DUES & SUBSCRIPTIONS		" "		75	75
18	V	21 CLERICAL		" "		2,678	2,678
19	V	24 TRAVEL		" "		5,321	5,321
20	V	26 INSURANCE		" "		2,344	2,344
21	V	30 DEPRECIATION		" "		460	460
22	V	34 RENT		" "		2,028	2,028
23	V	35 RENT - EQPT & VEHICLE		" "		6,104	6,104
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 119,393			\$ 98,888	\$ * (20,505)

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$ 294,624	THE KENSINGTON GROUP, LLC		\$ 3,077	\$ (291,547)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		748	748	16
17	V	21	CLERICAL		" "		248,590	248,590	17
18	V	24	TRAVEL		" "		7,315	7,315	18
19	V	26	INSURANCE		" "		3,281	3,281	19
20	V	30	DEPRECIATION		" "		5,276	5,276	20
21	V	34	RENT		" "		53,444	53,444	21
22	V	35	RENT - EQPT & VEHICLES		" "		1,688	1,688	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			\$ 294,624			\$ 323,419	\$ * 28,795	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$ 265,627	CHESTERFIELD, LLC		\$	\$ (265,627)	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			\$ 265,627			\$ 0	\$ * (265,627)	39

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

Facility Name &amp; ID Number

COUNTRYSIDE CARE CENTRE

#

0040931

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2009

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

1	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	19	PROFESSIONAL FEES	PATIENT DAYS	355,386	7	\$ 829,056	\$ 68,418	\$ 159,610	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	355,386	7	1,188	68,418	229	2
3	21	CLERICAL	PATIENT DAYS	355,386	7	67,323	68,418	12,961	3
4	24	TRAVEL	PATIENT DAYS	355,386	7	20,875	68,418	4,019	4
5	26	INSURANCE	PATIENT DAYS	355,386	7	8,960	68,418	1,725	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	355,386	7	35,397	68,418	6,815	6
7	30	DEPRECIATION	PATIENT DAYS	355,386	7	6,701	68,418	1,290	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					\$ 969,500	\$	\$ 186,649	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 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 CARLYLE NURSING ASSOC, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 78,675	\$ 78,675	1	\$ 78,675	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,656	68,418	1,203	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	68,418	75	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	68,418	2,678	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	68,418	5,321	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	68,418	2,344	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	68,418	460	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	68,418	2,028	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	549,185	11	48,990	68,418	6,104	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				\$ 240,906	\$ 78,675		\$ 98,888	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 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 THE KENSINGTON GROUP, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

1	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	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	\$ 24,702	\$ 68,418	\$ 3,077	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	68,418	748	2
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	68,418	26,803	3
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	68,418	7,315	4
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	68,418	3,281	5
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	68,418	5,276	6
7	34	RENT	PATIENT DAYS	549,185	11	428,990	68,418	53,444	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	549,185	11	13,546	68,418	1,688	8
9	21	CLERICAL	DIRECT HOURS	1	1	221,787	221,787	1	221,787
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					\$ 1,037,584	\$ 221,787	\$ 323,419	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

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	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE				\$	\$			\$	1										
2	CAPMARK	X	MORTGAGE	\$60,540.93	12/03	4,826,200	4,502,126	12/38	0.0540	244,789	2									
3	CAPMARK	X	LOAN COST	35 YR AMORT	12/03	44,896	37,137			1,283	3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LETTER OF CREDIT	X								1,379	6									
7	CHESTERFIELD	X	WORKING - CAPITAL	VARIES	12/98	498,989	973,695	DEMAND	VARIES	45,353	7									
8	MAXSOURCE	X	WORKING - CAPITAL			27,165	14,239			2,075	8									
9	TOTAL Facility Related			\$60,540.93		\$ 5,397,250	\$ 5,527,197			\$ 294,879	9									
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC	X	LATE FEES								10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 5,397,250	\$ 5,527,197			\$ 294,879	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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>171,350</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>193,854</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>22,504</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>203,500</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>226,004</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>130,117</b>	<b>8</b>
	2005	<b>139,081</b>	<b>9</b>
	2006	<b>146,807</b>	<b>10</b>
	2007	<b>169,483</b>	<b>11</b>
	2008	<b>193,854</b>	<b>12</b>

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED**

**ON - 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>15-19-176-009</u>	<u>NURSING HOME</u>	<u>\$ 193,854.36</u>	<u>\$ 193,854.36</u>
2.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
3.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
4.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
5.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
6.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
7.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
8.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
9.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
10.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
		<b>TOTALS</b>	<u>\$ 193,854.36</u>	<u>\$ 193,854.36</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207		1981		\$ 2,111,156	\$	30	\$ 70,372	\$ 70,372	\$ 1,992,382	4
5	754 BASIS ADJ.			1992	403,542	12,811	31.5	12,811		224,193	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	*****RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE										
10	BUILDING IMPROVEMENTS		1982		40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS		1983		26,282		15			26,282	11
12	VINYL TILING		1984		76,250		20			76,250	12
13	ROOF REPAIR		1985		6,644		20			6,644	13
14	VARIOUS IMPROVEMENTS		1986		1,609		15			1,609	14
15	VARIOUS IMPROVEMENTS		1987		36,433	1,157	31.5	1,157		26,001	15
16	BLACK TOP PAVING		1988		1,594		15			1,594	16
17	HOT WATER PIPING		1988		5,837	185	31.5	185		3,925	17
18	ROOFING IMPROVEMENTS		1989		51,879	1,647	31.5	1,647		34,107	18
19	SHOWER STALLS		1990		7,000	223	31.5	223		4,330	19
20	PAVING		1990		7,930		15			7,930	20
21	VARIOUS IMPROVEMENTS		1991		24,486	777	31.5	777		20,418	21
22	VARIOUS IMPROVEMENTS		1992		43,773	1,391	31.5	1,391		24,188	22
23	VARIOUS IMPROVEMENTS		1993		13,286	421	31.5	421		7,098	23
24	VARIOUS IMPROVEMENTS		1993		40,598	1,042	39	1,042		16,959	24
25	VARIOUS IMPROVEMENTS		1994		214,320	5,495	39	5,495		83,378	25
26	VARIOUS IMPROVEMENTS		1994		62,476	2,062	15	2,062		62,476	26
27	KITCHEN REMODEL /SIGNS		1995		32,836	842	39	842		12,562	27
28	ELECTRICAL & LIGHTING		1995		31,634	811	39	811		10,843	28
29	ROOFING/DOORS/DUCTWORK		1995		15,211	389	39	389		5,230	29
30	ROOF REPAIRS/FIRE DAMPERS		1996		4,300	110	39	110		1,528	30
31	BLACK TOP PAVING		1996		3,400	88	39	88		1,143	31
32	DUCTWORK		1996		8,584	220	39	220		2,869	32
33	REMOVE & REPLACE HVAC ROOF UNITS		1998		28,363	727	39	727		8,210	33
34	ROOF REPAIRS - PATCHING		1998		6,500	167	39	167		1,982	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST		1998		3,987	103	39	103		1,221	35
36	BOILER		1998		6,556	168	39	168		1,953	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 COUNTRYSIDE CARE CENTRE# 0040931

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	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	1999	\$ 58,243	\$ 2,118	27.5	\$ 2,118	\$	\$ 23,210	37
38	1999	27,515	1,001	27.5	1,001		10,878	38
39	1999	11,104	403	27.5	403		4,359	39
40	1999	165,984	6,035	27.5	6,035		64,628	40
41	1999	38,968	1,417	27.5	1,417		15,056	41
42	1999	26,186	953	27.5	953		10,037	42
43	1999	127,185	4,625	27.5	4,625		48,363	43
44	1999	26,058	948	27.5	948		9,827	44
45	1999	843,269	30,664	27.5	30,664		313,012	45
46	2000	72,465	2,635	27.5	2,635		26,240	46
47	2000	5,226	190	27.5	190		1,892	47
48	2000	64,257	2,337	27.5	2,337		22,487	48
49	2000	4,490	163	27.5	163		1,570	49
50	2000	7,595	276	27.5	276		2,611	50
51	2000	8,550	311	27.5	311		2,942	51
52	2000	5,282	192	27.5	192		1,800	52
53	2000	82,957	3,017	27.5	3,017		28,278	53
54	2000	8,604	313	27.5	313		2,908	54
55	2000	23,244	846	27.5	846		7,853	55
56	2000	6,184	225	27.5	225		2,091	56
57	2000	35,624	1,295	27.5	1,295		12,034	57
58	2000	92,626	3,369	27.5	3,369		31,015	58
59	2000	12,625	842	15	842		7,997	59
60	2000	67,311	2,448	27.5	2,448		22,535	60
61	2000	14,541	528	27.5	528		4,870	61
62	2000	1,399	51	27.5	51		470	62
63	2000	20,995	763	27.5	763		6,964	63
64	2000	103,610	3,768	27.5	3,768		34,376	64
65	2000	3,300	120	27.5	120		1,095	65
66	2000	11,211	408	27.5	408		3,688	66
67	2000	7,350	267	27.5	267		2,415	67
68	2000	109,053	3,966	27.5	3,966		35,853	68
69	2001	16,675	606	27.5	606		5,380	69
70		\$ 5,426,228	\$ 107,936		\$ 178,308	\$ 70,372	\$ 3,476,115	70

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2009 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,426,228	\$ 107,936		\$ 178,308	\$ 70,372	\$ 3,476,115	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		1,065	2
3	INSTALL HYDRAULIC PUMPING UNIT - KITCHEN ELEVATOR	2001	7,495	273	27.5	273		2,399	3
4	REPLACE WATER CLOSET & FLUSH VALVES - KITCHEN	2001	7,737	281	27.5	281		2,425	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		897	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		565	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	247	27.5	247		1,985	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		1,535	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HT.	2002	14,988	545	27.5	545		4,337	9
10	SHWR RM REPAIRS, REMOVE OLD & FURNISH/INSTL NEW	2002	26,388	960	27.5	960		7,635	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		606	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	75	27.5	75		534	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	55	27.5	55		388	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,831	15	5,831		43,960	14
15	F&I ONE INFRA RED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		325	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		314	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		563	17
18	2-452E SINGLE SOFTENER: 450,000 GRAINS	2003	9,598	349	27.5	349		2,254	18
19	SUPPLY & INSTALL WIRING FOR NEW 208 VOLT FREEZER	2003	1,651	60	27.5	60		378	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602, 611, 614, 705, 702	2003	3,666	133	27.5	133		805	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	923	27.5	923		5,114	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	82	27.5	82		442	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	133	27.5	133		714	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PRG	2004	3,751	250	15	250		1,375	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,951	27.5	2,951		15,613	25
26	COMPRESSOR	2004	2,100	76	27.5	76		403	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		265	27
28	NEW AZT FLOOR TILES FOR RMS 906, 812, 303, 512, 313, 314	2004	5,590	203	27.5	203		1,058	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	153	27.5	153		796	29
30	REPLACE FLOOR TILES & WALL TILES IN RMS 502, 505								30
31	506, 511, 512, 514, 805, & 807	2005	5,600	204	27.5	204		942	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS-1ST FLR W. WING	2005	28,000	1,019	27.5	1,019		4,709	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,779,286	\$ 123,540		\$ 193,912	\$ 70,372	\$ 3,580,516	34

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2009 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,779,286	\$ 123,540		\$ 193,912	\$ 70,372	\$ 3,580,516	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	161	27.5	161		746	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	1,656	27.5	1,656		7,522	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	3,837	27.5	3,837		17,427	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	453	27.5	453		2,059	5
6	REPLACE SIDE WALKS	2005	4,000	145	27.5	145		648	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	201	27.5	201		863	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	393	27.5	393		1,690	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	81	27.5	81		341	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	141	27.5	141		585	10
11	INSTALL 667 SQ YARDS OF NYLON CARPET	2005	38,420	1,397	27.5	1,397		5,763	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS								13
14	ELECTRICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	600	27.5	600		2,476	14
15	REPLACE ROOF TOP UNIT - 1ST FLOOR DINING RM.	2005	9,842	358	27.5	358		1,477	15
16	F&I ELEVATOR SYSTEM CONTROLLER & TAPE	2006	14,875	541	27.5	541		2,141	16
17	ELECTRICAL PANEL & VENTILATORS OUTLET	2006	15,755	573	27.5	573		2,268	17
18	110 YARDS OF INTERFACE CARPET TILES IN ACTIVITY	2006	5,612	646	5	561	(85)	3,927	18
19	INSTALL HOT WATER LINE - KITCHEN TO LAUNDRY RM	2006	1,560	57	27.5	57		220	19
20	REPLACE BAD IGNITION MODULE, FLAME SENSORS								20
21	IGNITOR, GAS REGULATOR	2006	3,290	120	27.5	120		454	21
22	6 WOOD DOORS & 18 HINGE HARDWARE	2006	2,951	107	27.5	107		407	22
23	WALLCOVERING FOR 600, 700, 800 LOUNGES	2006	3,165	364	5	317	(47)	2,216	23
24	INSTALL ELECTRICAL WIRING FOR OFFICE A/C	2006	1,535	56	27.5	56		198	24
25	REPLACED WATER HEATER	2006	14,013	510	27.5	510		1,720	25
26	6 WOOD DOORS & 18 HINGE HARDWARE	2006	3,368	122	27.5	122		403	26
27	COUNER TOPS FOR THERAPY ROOM	2007	714	26	27.5	26		76	27
28	INSTALL ELECTRICAL SUB PANELS IN CLOSET FOR CIRCU	2007	8,555	311	27.5	311		907	28
29	WALLPAPER , TILES - 1&2 FLR HALLWAYS & SHOWER RM	2007	115,000	4,181	27.5	4,181		11,848	29
30	FIRE DOOR	2007	1,932	70	27.5	70		199	30
31	INSTALLED VENDING MACHINE OUTLETS	2007	1,262	46	27.5	46		130	31
32	INSTALL MAIN EXHAUST FAN;REMODEL OF 8 SHOWER RM	2007	22,000	800	27.5	800		2,200	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,254,109	\$ 141,493		\$ 211,733	\$ 70,240	\$ 3,651,427	34

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

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2009 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,254,109	\$ 141,493		\$ 211,733	\$ 70,240	\$ 3,651,427	1
2	CERAMIC TILE FOR BATHROOMS	2007	3,378	123	27.5	123		328	2
3	BONDING MORTAR, SAND MIX: OUTLET COVERS - 1&2 FLR	2007	4,952	180	27.5	180		480	3
4	PIPE SHOWER VALVE; ATTACH GRID ON FLR DRAIN	2007	5,164	188	27.5	188		485	4
5	COMPLETE ROOF WORK	2007	81,900	2,979	27.5	2,979		7,694	5
6	TILES FOR FLOOR & WALLS - SHOWER ROOMS	2007	9,883	359	27.5	359		898	6
7	PATCH/REPAIR VISIBLE CRACKS-ROOF AND 600, 900 WING	2007	2,300	84	27.5	84		202	7
8	REPAIR HOT WATER LINE & REPLACE BATH RM VALVES	2007	1,751	64	27.5	64		149	8
9	MATERIALS FOR BATHROOM REMODEL	2007	9,451	343	27.5	343		773	9
10	PIPED IN 4 NEW SHOWER VALVES ALONG WITH BREAKER	2007	2,223	80	27.5	80		168	10
11	INSTALL 208 VOLT OUTLET IN KITCHEN	2007	882	32	27.5	32		67	11
12	INSTALL 2 SHOWER VALVES & REPIPED DRAIN	2007	1,195	44	27.5	44		91	12
13	REPLACE SOUTHWEST EXIT DOOR	2007	1,674	61	27.5	61		127	13
14	WALL COVERING, BORDERS, BLINDS, VALANCES FOR								14
15	1ST & 2ND FLR DINING RMS, RESIDENT ROOMS	2007	99,417	3,616	27.5	3,616		7,532	15
16	MATERIALS LIKE GROUT, TILE, GLOSS BISC, FLANGE								16
17	FOR BATHROOM REMODEL	2007	2,224	81	27.5	81		162	17
18	WALL PROTECTION SYSTEM FOR 1ST & 2ND FLOOR	2008	87,062	3,166	27.5	3,166		6,332	18
19	HVAC INSTALLATION	2008	3,800	138	27.5	138		276	19
20	2ND & 1ST FLOORS-WALLPAPER, BORDERS, TILES	2008	37,939	1,379	27.5	1,379		1,954	20
21	900 WING FLOOR & CEILING TILING, DRYWALL	2008	28,478	1,035	27.5	1,035		1,294	21
22	MOKE DOORS & THE HARDWARE FOR THE DOORS	2008	8,397	306	27.5	306		382	22
23	FURNISH & INSTALL ENCASED IN PVC FOR ELEVATOR	2008	19,985	727	27.5	727		1,211	23
24	ROOF REPLACEMENT	2008	165,800	6,029	27.5	6,029		8,039	24
25	NEW BREAKER, OUTLET IN KITCHEN & PIPING	2008	8,751	318	27.5	318		398	25
26	FIRST FLOOR-TILES IN SHOWER ROOM, WALLPAPERING	2008	122,851	4,467	27.5	4,467		4,467	26
27	FIRE PROTECTION SYSTEM UNDER CANOPY	2008	12,720	463	27.5	463		540	27
28	INSTALL THERO PANES IN LOUNGE AND CAFETERIA	2008	2,283	83	27.5	83		97	28
29	ALZHEIMERS ROOMS-BLINDS & BORDERS	2008	1,283	47	27.5	47		51	29
30	DIG AND RUN NEW FLOOR DRAIN	2009	8,750	239	27.5	239		239	30
31	REPLACE TOILETS AND ATTACH TO NEW DRAIN	2009	3,205	49	27.5	49		49	31
32	UNILOCK BRICK/CEMENT INSTALLATION - PATIO	2009	12,139	221	27.5	221		221	32
33	REPLACE TILE, FAUCETS - 400,600,& 800 WINGS	2009	7,170	109	27.5	109		109	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,011,116	\$ 168,503		\$ 238,743	\$ 70,240	\$ 3,696,242	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	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		\$ 7,011,116	\$ 168,503		\$ 238,743	\$ 70,240	\$ 3,696,242	1
2		3,060	37	27.5	37		37	2
3		5,000	61	27.5	61		61	3
4								4
5		ADJ. TO SL	70,240			(70,240)		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		\$ 7,019,176	\$ 238,841		\$ 238,841	\$	\$ 3,696,340	34

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,467,304	\$ 99,088	\$ 128,613	\$ 29,525		\$ 788,287	71
72	Current Year Purchases	247,659	148,595	12,383	(136,212)		12,383	72
73	Fully Depreciated Assets	146,503					146,503	73
74	<b>RELATED PARTY</b>		7,026	7,026				74
75	<b>TOTALS</b>	\$ 1,861,466	\$ 254,709	\$ 148,022	\$ (106,687)		\$ 947,173	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,994,987	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 493,550	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 386,863	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (106,687)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,643,513	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	<b>TOTAL</b>				\$			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: \$ 26,752 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>ADMINISTRATIVE</u>	<u>2008 FORD E350</u>	\$ <u>#####</u>	\$ <u>15,926</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>#####</u>	\$ <u>15,926</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. \_\_\_\_\_ /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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 495,288	\$		\$ 495,288	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			93,626			93,626	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			627,883			627,883	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				277,731		277,731	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					78,714		78,714	13
14	<b>TOTAL</b>			\$		\$ 1,216,797	\$ 356,445		\$ 1,573,242	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 &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2009

Ending:

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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 151,514	\$ 217,999	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 688,897 )	2,522,360	2,522,360	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,883	1,883	5
6	Prepaid Insurance	62,046	120,327	6
7	Other Prepaid Expenses	22,780	24,670	7
8	Accounts Receivable (owners or related parties)	880	6,982	8
9	Other(specify): <b>ESCROW DEPOSITS</b>		317,173	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,761,463	\$ 3,211,394	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		6,615,631	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,861,469	1,861,469	16
17	Accumulated Depreciation (book methods)	(1,629,222)	(5,045,058)	17
18	Deferred Charges		37,137	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</b> (sum of lines 11 thru 23)	\$ 232,247	\$ 3,567,179	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,993,710	\$ 6,778,573	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,168,229	\$ 1,201,371	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,040	59,040	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,573	47,573	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,076	67,076	31
32	Accrued Real Estate Taxes(Sch.IX-B)		203,500	32
33	Accrued Interest Payable	2,681	22,941	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>MANAGEMENT FEES</b>	1,988,114	1,988,114	36
37	<b>DUE TO LESSOR/PRIOR OWNER</b>	2,334,705		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,667,418	\$ 3,589,615	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,319,683	4,176,552	39
40	Mortgage Payable		4,502,126	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</b> (sum of lines 39 thru 44)	\$ 3,319,683	\$ 8,678,678	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 8,987,101	\$ 12,268,293	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (5,993,391)	\$ (5,489,720)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,993,710	\$ 6,778,573	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(6,855,520)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>	<b>2</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>(6,855,518)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>862,127</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>862,127</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>(5,993,391)</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	\$ 13,714,622	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,714,622	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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***	32,171	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 32,171	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>	\$ 13,746,793	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,759,015	31
32	Health Care	4,718,858	32
33	General Administration	3,384,452	33
<b>B. Capital Expense</b>			
34	Ownership	1,328,022	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,573,242	35
36	Provider Participation Fee	111,143	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>	9,934	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,884,666	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	862,127	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 862,127	43

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

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

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

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

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

# **0040931**

Report Period Beginning:

**01/01/2009**

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	2,077	2,501	\$ 86,105	\$ 34.43	1
2	Assistant Director of Nursing	2,033	2,274	73,135	32.16	2
3	Registered Nurses	28,030	31,254	901,592	28.85	3
4	Licensed Practical Nurses	33,986	36,975	985,145	26.64	4
5	CNAs & Orderlies	116,957	125,298	1,683,013	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,873	4,409	127,071	28.82	8
9	Activity Director	3,611	4,121	64,029	15.54	9
10	Activity Assistants	5,605	6,148	61,313	9.97	10
11	Social Service Workers	5,243	5,796	94,514	16.31	11
12	Dietician					12
13	Food Service Supervisor	3,989	4,545	85,619	18.84	13
14	Head Cook	5,428	5,910	67,933	11.49	14
15	Cook Helpers/Assistants	21,223	22,512	199,046	8.84	15
16	Dishwashers					16
17	Maintenance Workers	1,903	2,190	52,771	24.10	17
18	Housekeepers	27,574	29,716	300,007	10.10	18
19	Laundry	1,981	2,233	28,916	12.95	19
20	Administrator	1,874	2,222	161,448	72.66	20
21	Assistant Administrator	1,957	2,158	53,280	24.69	21
22	Other Administrative					22
23	Office Manager	7,023	7,860	192,075	24.44	23
24	Clerical	4,022	4,261	48,951	11.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,090	4,932	137,945	27.97	31
32	Other Health Care <u>WARD CLERKS</u>	4,256	4,860	72,907	15.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	286,735	312,175	\$ 5,476,815 *	\$ 17.54	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	300	\$ 20,266	1-3	35
36	Medical Director	96	9,000	9-3	36
37	Medical Records Consultant	20	968	10-3	37
38	Nurse Consultant	947	119,393	10-3	38
39	Pharmacist Consultant	88	2,200	10-3	39
40	Physical Therapy Consultant	2	271	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	51	3,054	11-3	44
45	Social Service Consultant	116	14,251	12-3	45
46	Other(specify)			10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,620	\$ 169,403		49

**C. CONTRACT NURSES**

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



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	2006	\$ 1,961	3	\$ 326	\$ 654	\$ 654	\$ 327	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,961		\$ 326	\$ 654	\$ 654	\$ 327	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILL. COUNCIL ON LTC. - \$16552.80
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,499 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. \$ 111,143  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
  - d. Have vehicle usage logs been maintained? NO
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
  - g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (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.