FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0040931

Facility Name: COUNTRYSIDE CARE CENTRE

Address: 2330 WEST GALENA BOULEVARD (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MICHAEL C. BRAUN **Telephone Number:** (847) 583-0100 X 126
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MICHAEL C. BRAUN
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,727	1,543	6,779	19,049	8
9	SNF/PED					9
10	ICF	39,804	5,726	4,065	49,595	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,531	7,269	10,844	68,644	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.64%

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 [X]

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

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 [x] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 203 and days of care provided 5,684

Medicare Intermediary WPS(WISCONSIN PHYSICIAN SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	414,574	64,041	22,812	501,427		501,427	(26,415)	475,012			1
2	Food Purchase		363,809		363,809		363,809	(5,148)	358,661			2
3	Housekeeping	319,943	89,123		409,066		409,066	(3,156)	405,910			3
4	Laundry	31,197	31,418	8,251	70,866		70,866	(2,541)	68,325			4
5	Heat and Other Utilities			255,752	255,752		255,752		255,752			5
6	Maintenance	59,525	78,243	55,132	192,900		192,900	(1,105)	191,795			6
7	Other (specify):*			63,222	63,222		63,222		63,222			7
8	TOTAL General Services	825,239	626,634	405,169	1,857,042		1,857,042	(38,365)	1,818,677			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,950,893	306,297	120,217	4,377,407		4,377,407	(5,847)	4,371,560			10
10a	Therapy	79,695			79,695		79,695		79,695			10a
11	Activities	126,824	6,590	21,734	155,148		155,148	8,903	164,051			11
12	Social Services	64,251		15,590	79,841		79,841		79,841			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,221,663	312,887	166,541	4,701,091		4,701,091	3,056	4,704,147			16
	C. General Administration											
17	Administrative	224,667		522,020	746,687		746,687	(520,837)	225,850			17
18	Directors Fees											18
19	Professional Services			433,845	433,845		433,845	(111,114)	322,731			19
20	Dues, Fees, Subscriptions & Promotions			149,145	149,145		149,145	(112,643)	36,502			20
21	Clerical & General Office Expenses	278,265	53,822	81,704	413,791		413,791	271,776	685,567			21
22	Employee Benefits & Payroll Taxes			1,058,119	1,058,119		1,058,119		1,058,119			22
23	Inservice Training & Education			10,623	10,623		10,623		10,623			23
24	Travel and Seminar			355	355		355	16,997	17,352			24
25	Other Admin. Staff Transportation			5,673	5,673		5,673		5,673			25
26	Insurance-Prop.Liab.Malpractice			325,136	325,136		325,136	5,012	330,148			26
27	Other (specify):*			259,198	259,198		259,198	(259,198)				27
28	TOTAL General Administration	502,932	53,822	2,845,818	3,402,572		3,402,572	(710,007)	2,692,565			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,549,834	993,343	3,417,528	9,960,705		9,960,705	(745,316)	9,215,389			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#: COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,374	
	REPAIRS & MAINTENANCE		3,438	
			0	22,812
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,251	
			0	8,251
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		58,855	
	ELECTRICITY		106,373	
	WATER		90,524	
	CABLE TV - LOBBY		0	
			0	255,752
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		19,177	
	PAINTING & DECORATING		4,678	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,647	
	ELEVATOR MAINTENANCE & REPAIR		6,562	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,475	
	FIRE SERVICE		7,593	
			0	
			0	
			0	
			0	55,132
7	**OTHER**			
	SCAVENGER		57,577	
	SECURITY SERVICE		5,645	
			0	
			0	63,222
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,558	
	PHARMACY CONSULTANT	XVIII B 39-2	9,215	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	109,444	
			0	
			0	120,217
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		18,784	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,950	
			0	21,734
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	14,750	
	SOCIAL WORKER	XVIII B 45-2	840	
			0	15,590
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	522,020	522,020
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,924	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	405,921	
			0	433,845
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	68,422	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,036	
	EMPLOYEE WANT ADS	XIX F	9,524	
	CONTRIBUTIONS	VI 20 XIX F	1,590	
	DUES & SUBSCRIPTIONS	XIX F	13,730	
	LICENSES & PERMITS	XIX F	6,863	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	26,791	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,529	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,120	
	PATIENT BACKGROUND CHECKS	XIX F	4,540	
				149,145
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,847	
	EQUIPMENT REPAIR & MAINTENANCE		58	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	23,384	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		49,093	
	MESSENGER SERVICE		4,322	
			0	81,704

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	415,092	
	UNEMPLOYMENT COMPENSATION	XIX D	56,124	
	WORKERS COMPENSATION INSURANC	XIX D	118,709	
	HOSPITALIZATION INSURANCE	XIX D	439,668	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,291	
	EMPLOYEE PHYSICAL EXAMS	XIX D	4,185	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	14,050	
	CHICAGO HEAD TAX	XIX D	0	
			0	1,058,119
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,623	
				10,623
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	355	
				355
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,673	
				5,673
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		325,136	
				325,136
27	**OTHER**			
	BAD DEBTS	VI 24	259,198	
				259,198

GRAND TOTAL COLUMN 3 OTHER **3,417,528**

COUNTRYSIDE CARE CENTRE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	363,809
LESS SALES TAX	(5,148)
NET FOOD	358,661
TOTAL PATIENT CENSUS	68,644
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	205,932
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	205,932
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	205,932
NET FOOD	358,661
DIVIDE TOTAL MEALS/YEAR	205,932
COST PER MEAL	1.74
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			249,107	249,107		249,107	192,443	441,550			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,377	58,377		58,377	213,492	271,869			32
33	Real Estate Taxes			147,914	147,914		147,914		147,914			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(699,539)	63,311			34
35	Rent-Equipment & Vehicles			55,046	55,046		55,046	13,992	69,038			35
36	Other (specify):* MTG INSURANCE							22,334	22,334			36
37	TOTAL Ownership			1,273,294	1,273,294		1,273,294	(257,278)	1,016,016			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		304,426	1,249,581	1,554,007		1,554,007		1,554,007			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	TOTAL Special Cost Centers		304,426	1,360,724	1,665,150		1,665,150		1,665,150			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,549,834	1,297,769	6,051,546	12,899,149		12,899,149	(1,002,594)	11,896,555			45

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,366)	30		9
10	Interest and Other Investment Income	(29,098)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,148)	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	(23,384)	21		18
19	Entertainment	(68,422)	20		19
20	Contributions	(10,119)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,184)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(259,198)	27		24
25	Fund Raising, Advertising and Promotional	(8,036)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(26,791)	20		28
29	Other-Attach Schedule	(17,900)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (516,646)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(485,948)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (485,948)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,002,594)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

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

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL	(26,415)	1	2
3	VACATION ACCRUAL	(3,156)	3	3
4	VACATION ACCRUAL	(2,541)	4	4
5	VACATION ACCRUAL	(1,105)	6	5
6	VACATION ACCRUAL	4,289	10	6
7	VACATION ACCRUAL	8,903	11	7
8	VACATION ACCRUAL	1,183	17	8
9	VACATION ACCRUAL	5,007	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(250)	19	11
12	MARKETING CONSULTANT	(1,815)	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	**Total**	(17,900)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE **#** 0040931 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(26,415)	0	0	0	0	0	0	0	0	0	0	(26,415)	1
2	Food Purchase	(5,148)	0	0	0	0	0	0	0	0	0	0	(5,148)	2
3	Housekeeping	(3,156)	0	0	0	0	0	0	0	0	0	0	(3,156)	3
4	Laundry	(2,541)	0	0	0	0	0	0	0	0	0	0	(2,541)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,105)	0	0	0	0	0	0	0	0	0	0	(1,105)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(38,365)	0	0	0	0	0	0	0	0	0	0	(38,365)	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	4,289	0	0	(10,136)	0	0	0	0	0	0	0	(5,847)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	8,903	0	0	0	0	0	0	0	0	0	0	8,903	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**	13,192	0	0	(10,136)	0	0	0	0	0	0	0	3,056	16
	C. General Administration													
17	Administrative	1,183	0	(261,010)	0	0	(261,010)	0	0	0	0	0	(520,837)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,249)	36,236	153,441	3,345	(292,887)	0	0	0	0	0	0	(111,114)	19
20	Fees, Subscriptions & Promotions	(113,368)	0	248	104	373	0	0	0	0	0	0	(112,643)	20
21	Clerical & General Office Expenses	(18,377)	0	16,876	7,529	265,748	0	0	0	0	0	0	271,776	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	3,326	5,788	7,883	0	0	0	0	0	0	16,997	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	973	2,428	1,611	0	0	0	0	0	0	5,012	26
27	Other (specify):*	(259,198)	0	0	0	0	0	0	0	0	0	0	(259,198)	27
28	**TOTAL General Administration**	(401,009)	36,236	(86,146)	19,194	(17,272)	(261,010)	0	0	0	0	0	(710,007)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(426,182)	36,236	(86,146)	9,058	(17,272)	(261,010)	0	0	0	0	0	(745,316)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,366)	246,319	2,255	1,125	4,110	0	0	0	0	0	0	192,443	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,098)	242,590	0	0	0	0	0	0	0	0	0	213,492	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	2,048	61,263	0	0	0	0	0	0	(699,539)	34
35	Rent-Equipment & Vehicles	0	0	6,510	5,680	1,802	0	0	0	0	0	0	13,992	35
36	Other (specify):*	0	22,334	0	0	0	0	0	0	0	0	0	22,334	36
37	TOTAL Ownership	(90,464)	(251,607)	8,765	8,853	67,175	0	0	0	0	0	0	(257,278)	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)	(516,646)	(215,371)	(77,381)	17,911	49,903	(261,010)	0	0	0	0	0	(1,002,594)	45

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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		COUNTRYSIDE HEALTH CARE CENTRE		
		NURSING HOMES			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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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		" "		22,334	22,334	2
3	V	30	DEPRECIATION - BLDG/IMP		" "		246,319	246,319	3
4	V				" "				4
5	V	32	AMORTIZATION - MTG COST		" "		1,283	1,283	5
6	V	32	INTEREST - MORTGAGE		" "		241,307	241,307	6
7	V				" "				7
8	V	19	ACCOUNTING FEES		" "		26,086	26,086	8
9	V	19	DATA PROCESSING		" "		50	50	9
10	V				" "				10
11	V	19	OTHER PROFESSIONAL		" "		10,100	10,100	11
12	V								12
13	V								13
14	Total			$ 762,850			$ 547,479	$ * (215,371)	14

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES		$ 153,441	$ 153,441	15
16	V	20	DUES & SUBSCRIPTIONS		" "		248	248	16
17	V	21	CLERICAL		" "		16,876	16,876	17
18	V	24	TRAVEL		" "		3,326	3,326	18
19	V	26	INSURANCE		" "		973	973	19
20	V	35	RENT - EQPT & VEHICLE		" "		6,510	6,510	20
21	V	17	ADMINISTRATIVE	261,010	" "			(261,010)	21
22	V	30	DEPRECIATION		" "		2,255	2,255	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			$ 261,010			$ 183,629	$ * (77,381)	39

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 109,443	CARLYLE NURSING ASSOCIATES, LLC		$ 99,307	$ (10,136)	15
16	V	19	PROFESSIONAL FEES		" "		3,345	3,345	16
17	V	20	DUES & SUBSCRIPTIONS		" "		104	104	17
18	V	21	CLERICAL		" "		7,529	7,529	18
19	V	24	TRAVEL		" "		5,788	5,788	19
20	V	26	INSURANCE		" "		2,428	2,428	20
21	V	30	DEPRECIATION		" "		1,125	1,125	21
22	V	34	RENT		" "		2,048	2,048	22
23	V	35	RENT - EQPT & VEHICLE		" "		5,680	5,680	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			$ 109,443			$ 127,354	$ * 17,911	39

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 295,207	THE KENSINGTON GROUP, LLC		$ 2,320	$ (292,887)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		373	373	16
17	V	21	CLERICAL		" "		265,748	265,748	17
18	V	24	TRAVEL		" "		7,883	7,883	18
19	V	26	INSURANCE		" "		1,611	1,611	19
20	V	30	DEPRECIATION		" "		4,110	4,110	20
21	V	34	RENT		" "		61,263	61,263	21
22	V	35	RENT - EQPT & VEHICLES		" "		1,802	1,802	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			$ 295,207			$ 345,110	$ * 49,903	39

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 261,010	CHESTERFIELD, LLC		$	$ (261,010)	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			$ 261,010			$ 0	$ * (261,010)	39

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	361,812	7	$ 808,776	$	68,644	$ 153,441	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	361,812	7	1,305		68,644	248	2
3	21	CLERICAL	PATIENT DAYS	361,812	7	88,950		68,644	16,876	3
4	24	TRAVEL	PATIENT DAYS	361,812	7	17,533		68,644	3,326	4
5	26	INSURANCE	PATIENT DAYS	361,812	7	5,130		68,644	973	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	361,812	7	34,314		68,644	6,510	6
7	30	DEPRECIATION	PATIENT DAYS	361,812	7	11,887		68,644	2,255	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					$ 967,895	$		$ 183,629	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 99,307	$ 99,307	1	$ 99,307	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	11	26,955		68,644	3,345	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	11	842		68,644	104	3
4	21	CLERICAL	PATIENT DAYS	552,974	11	60,665		68,644	7,529	4
5	24	TRAVEL	PATIENT DAYS	552,974	11	46,637		68,644	5,788	5
6	26	INSURANCE	PATIENT DAYS	552,974	11	19,567		68,644	2,428	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	11	9,065		68,644	1,125	7
8	34	RENT	PATIENT DAYS	552,974	11	16,500		68,644	2,048	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	552,974	11	45,767		68,644	5,680	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					$ 325,305	$ 99,307		$ 127,354	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	552,954	11	$ 18,688	$	68,644	$ 2,320	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004		68,644	373	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775		68,644	24,924	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497		68,644	7,883	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980		68,644	1,611	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106		68,644	4,110	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503		68,644	61,263	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	552,954	11	14,513		68,644	1,802	8
9	21	CLERICAL	DIRECT HOURS	1	1	240,824	240,824	1	240,824	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					$ 1,080,890	$ 240,824		$ 345,110	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE						$	$			$	1
2	BERKADIA		X	MORTGAGE	$60,540.93	12/03	4,826,200	4,436,405	12/38	0.0540	241,307	2
3	BERKADIA		X	LOAN COST	35 YR AMORT	12/03	44,896	35,854			1,283	3
4												4
5												5
	Working Capital											
6	LETTER OF CREDIT		X									6
7	CHESTERFIELD	X		WORKING - CAPITAL	VARIES	12/98	498,989	4,675,658	DEMAND	VARIES	56,238	7
8	MAXSOURCE		X	WORKING - CAPITAL			27,165				2,139	8
9	TOTAL Facility Related				$60,540.93		$ 5,397,250	$ 9,147,917			$ 300,967	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,397,250	$ 9,147,917			$ 300,967	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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.)**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 203,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 171,414	2
3. Under or (over) accrual (line 2 minus line 1).		$ (32,086)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 147,914	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	139,081	8
	2006	146,807	9
	2007	169,483	10
	2008	193,854	11
	2009	171,414	12

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 2009 TAX BILL.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT MICHAEL C. BRAUN

TELEPHONE (847) 583-0100 X 126 FAX #: (847) 583-8873

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	NURSING HOME	$ 171,413.78	$ 171,413.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 171,413.78	$ 171,413.78

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	207		1981		$ 2,111,156	$	30	$ 70,372	$ 70,372	$ 2,062,754	4
5	754 BASIS ADJ.			1992	403,542	14,674	27.5	14,674		238,867	5
6	754 BASIS ADJ.			2008	22,024	801	27.5	801		2,236	6
7											7
8											8
	Improvement Type**										
9	*****RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE****										9
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	V			1987	36,433	1,325	27.5	1,325		27,326	15
16	BLACK TOP PAVING			1988	1,594		15			1,594	16
17	HOT WATER PIPING			1988	5,837	212	27.5	212		4,137	17
18	ROOFING IMPROVEMENTS			1989	51,879	1,886	27.5	1,886		35,993	18
19	SHOWER STALLS			1990	7,000	254	27.5	254		4,584	19
20	PAVING			1990	7,930		15			7,930	20
21	VARIOUS IMPROVEMENTS			1991	24,486	890	27.5	890		21,308	21
22	VARIOUS IMPROVEMENTS			1992	43,773	1,592	27.5	1,592		25,780	22
23	VARIOUS IMPROVEMENTS			1993	13,286	483	27.5	483		7,581	23
24	VARIOUS IMPROVEMENTS			1993	40,598	1,475	27.5	1,475		18,434	24
25	VARIOUS IMPROVEMENTS			1994	214,320	7,794	27.5	7,794		91,172	25
26	VARIOUS IMPROVEMENTS			1994	62,476		15			62,476	26
27	KITCHEN REMODEL/SIGNS			1995	32,836	1,194	27.5	1,194		13,756	27
28	ELECTRICAL & LIGHTING			1995	31,634	1,151	27.5	1,151		11,994	28
29	ROOFING/DOORS/DUCTWORK			1995	15,211	553	27.5	553		5,783	29
30	ROOF REPAIRS/FIRE DAMPES			1996	4,300	156	27.5	156		1,684	30
31	BLACK TOP PAVING			1996	3,400	123	27.5	123		1,266	31
32	DUCTWORK			1996	8,584	312	27.5	312		3,181	32
33	REMOVE & REPLACE HAVC ROOF UNITS			1998	28,363	1,031	27.5	1,031		9,241	33
34	ROF REPAIRS - PATCHING			1998	6,500	236	27.5	236		2,218	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST			1998	3,987	145	27.5	145		1,366	35
36	BOILER			1998	6,556	239	27.5	239		2,192	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALLCOVERING, CARPETING,ARCHITECT WORK	1999	$ 58,243	$ 2,118	27.5	$ 2,118	$	$ 25,328	37
38	WALLCOVERING/ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		11,878	38
39	REMODEL KITCHEN/WALLCOVERING/DRYWALL	1999	11,104	404	27.5	404		4,763	39
40	DINING RMS/WASHROOM - REMODEL/NEW ROOF	1999	165,984	6,036	27.5	6,036		70,664	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		16,473	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		10,989	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,625	27.5	4,625		52,988	43
44	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	947	27.5	947		10,774	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,664	27.5	30,664		343,676	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		28,875	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		2,082	47
48	DOORS/LAUNDRY RM/CORRIDOR REMODEL	2000	64,257	2,336	27.5	2,336		24,823	48
49	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		1,733	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	277	27.5	277		2,888	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		3,253	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		1,992	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		31,294	53
54	HOT WATER REC, - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	312	27.5	312		3,220	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		8,698	55
56	FIRE ALARM/DOORS	2000	6,184	224	27.5	224		2,315	56
57	PARKING LOT EXPANSION	2000	35,624	1,296	27.5	1,296		13,330	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		34,383	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		8,839	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,448	27.5	2,448		24,983	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		5,399	61
62	STIR FREE LINT FILTER	2000	1,399	50	27.5	50		520	62
63	NEW ROOF	2000	20,995	764	27.5	764		7,728	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,768	27.5	3,768		38,144	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		1,215	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	408	27.5	408		4,096	66
67	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		2,682	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		39,818	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	606	27.5	606		5,986	69
70	TOTAL (lines 4 thru 69)		$ 5,448,252	$ 113,621		$ 183,993	$ 70,372	$ 3,661,543	70

**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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,448,252	$ 113,621		$ 183,993	$ 70,372	$ 3,661,543	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		1,185	2
3	INSTALL HYDRAULIC PUMPING UNIT - KITCHEN ELEVAT	2001	7,495	272	27.5	272		2,671	3
4	REPLACE WATER CLOSET & FLUSH VALVES - KITCHEN	2001	7,737	281	27.5	281		2,706	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		1,002	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		631	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LIN	2001	6,783	247	27.5	247		2,232	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	192	27.5	192		1,727	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HT	2002	14,988	545	27.5	545		4,882	9
10	SHOWR RM REPAIRS, REMOVE OLD & FURNISH/INSTL NE	2002	26,388	959	27.5	959		8,594	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		689	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		608	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	56	27.5	56		444	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,832	15	5,832		49,792	14
15	F&I ONE INFRA RED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		374	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/12 CK VALVE	2003	1,320	48	27.5	48		362	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		650	17
18	2-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		2,603	18
19	SUPPLY & INSTALL WIRING FOR NEW 208 VOLT FREEZEI	2003	1,651	60	27.5	60		438	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602, 611, 614, 705, 70	2003	3,666	133	27.5	133		938	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	923	27.5	923		6,037	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	82	27.5	82		524	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	132	27.5	132		846	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PRO	2004	3,751	250	15	250		1,625	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,951	27.5	2,951		18,564	25
26	COMPRESSOR	2004	2,100	76	27.5	76		479	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		315	27
28	NEW AZT FLOOR TILES FOR RMS 906, 812, 303, 512, 313, 314	2004	5,590	203	27.5	203		1,261	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	153	27.5	153		949	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		1,146	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS-1ST FLR W. WINC	2005	28,000	1,018	27.5	1,018		5,727	33
34	TOTAL (lines 1 thru 33)		$ 5,801,310	$ 129,221		$ 199,593	$ 70,372	$ 3,781,544	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,801,310	$ 129,221		$ 199,593	$ 70,372	$ 3,781,544	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	162	27.5	162		908	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	1,656	27.5	1,656		9,178	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	3,837	27.5	3,837		21,264	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	454	27.5	454		2,513	5
6	REPLACE SIDE WALKS	2005	4,000	146	27.5	146		794	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	201	27.5	201		1,064	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	394	27.5	394		2,084	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	82	27.5	82		423	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	142	27.5	142		727	10
11	INSTALL 665 SQ YARDS OF NYLON CARPET	2005	38,420	1,397	27.5	1,397		7,160	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS								13
14	ELECTRICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	601	27.5	601		3,077	14
15	REPLACE ROOF TOP UNIT - 1ST FLOOR DINING RM.	2005	9,842	358	27.5	358		1,835	15
16	F&I ELEVATOR SYSTEM CONTROLLER & TAPE	2006	14,875	541	27.5	541		2,682	16
17	ELECTRICAL PANEL & VENTILATORS OUTLET	2006	15,755	573	27.5	573		2,841	17
18	110 YARDS OF INTERFACE CARPET TILES IN ACTIVITY	2006	5,612	647	10	561	(86)	4,488	18
19	INSTALL HOT WATER LINE - KITCHEN TO LAUNDRY RM	2006	1,560	57	27.5	57		277	19
20	REPLACE BAD IGNITION MODULE, FLAME SENSORS								20
21	IGNITOR, GAS REGULATOR	2006	3,290	119	27.5	119		573	21
22	6 WOOD DOORS & 18 HINGE HARDWARE	2006	2,951	107	27.5	107		514	22
23	WALLCOVERING FOR 600, 700, 800 LOUNGES	2006	3,165	365	10	317	(48)	2,533	23
24	INSTALL ELECTRICAL WIRING FOR OFFICE A/C	2006	1,535	56	27.5	56		254	24
25	REPLACED WATER HEATER	2006	14,013	509	27.5	509		2,229	25
26	6 WOOD DOORS & 18 HINGE HARDWARE	2006	3,368	123	27.5	123		526	26
27	COUNTER TOPS FOR THERAPY ROOM	2007	714	26	27.5	26		102	27
28	INSTALL ELECTRICAL SUB PANELS IN CLOSET FOR CIRC	2007	8,555	311	27.5	311		1,218	28
29	WALLPAPER, TILES - 1&2 FLR HALLWAYS & SHOWER RM	2007	115,000	4,182	27.5	4,182		16,030	29
30	FIRE DOOR	2007	1,932	70	27.5	70		269	30
31	INSTALLED VENDING MACHINE OUTLETS	2007	1,262	46	27.5	46		176	31
32	INSTALL MAIN EXHAUST FAN;REMODEL 8 SHOWER RMS	2007	22,000	800	27.5	800		3,000	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,276,133	$ 147,183		$ 217,421	$ 70,238	$ 3,870,283	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,276,133	$ 147,183		$ 217,421	$ 70,238	$ 3,870,283	1
2	CERAMIC TILE FOR BATHROOMS	2007	3,378	122	27.5	122		450	2
3	BONDING MORTAR, SAND MIX; OUTLET COVERS - 1&2 FL	2007	4,952	180	27.5	180		660	3
4	PIPE SHOWER VALVE; ATTACH GRID ON FLR DRAIN	2007	5,164	188	27.5	188		673	4
5	COMPLETE ROOF WORK	2007	81,900	2,978	27.5	2,978		10,672	5
6	TILES FOR FLOOR & WALLS - SHOWER ROOMS	2007	9,883	360	27.5	360		1,258	6
7	PATCH/REPAIR VISIBLE CRACKS-ROOF AND 600, 900 WIN	2007	2,300	84	27.5	84		286	7
8	REPAIR HOT WATER LINE & REPLACE BATH RM VALVES	2007	1,751	63	27.5	63		212	8
9	MATERIALS FOR BATHROOM REMODEL	2007	9,451	344	27.5	344		1,117	9
10	PIPED IN 4 NEW SHOWER VALVES ALONG WITH BREAKE	2007	2,223	81	27.5	81		249	10
11	INSTALL 208 VOLT OUTLET IN KITCHEN	2007	882	32	27.5	32		99	11
12	INSTALLED 2 SHOWER VALVES & REPIPED DRAIN	2007	1,195	43	27.5	43		134	12
13	REPLACE SOUTHWEST EXIT DOOR	2007	1,674	61	27.5	61		188	13
14	WALL COVERING, BORDERS, BLINDS, VALANCES FOR								14
15	1ST & 2ND FLR DINING RMS, RESIDENT ROOMS	2007	99,417	3,615	27.5	3,615		11,147	15
16	MATERIALS LIKE GROUT, TILE, GLOSS BISC, FLANGE								16
17	FOR BATHROOM REMODEL	2007	2,224	81	27.5	81		243	17
18	WALL PROTECTION SYSTEM FOR 1ST & 2ND FLOOR	2008	87,062	3,166	27.5	3,166		9,498	18
19	HVAC INSTALLATION	2008	3,800	139	27.5	139		415	19
20	2ND & 1ST FLOORS-WALLPAPER, BORDERS, TILES	2008	37,939	1,380	27.5	1,380		3,334	20
21	900 WING FLOOR & CEILING TILING, DRYWALL	2008	28,478	1,036	27.5	1,036		2,330	21
22	SMOKE DOORS & THE HARDWARE FOR THE DOORS	2008	8,397	305	27.5	305		687	22
23	FURNISH & INSTALL ENCASED-IN PVC FOR ELEVATOR	2008	19,985	727	27.5	727		1,938	23
24	ROOF REPLACEMENT	2008	165,800	6,029	27.5	6,029		14,068	24
25	NEW BREAKER, OUTLET IN KITCHEN & PIPING	2008	8,751	318	27.5	318		716	25
26	FIRST FLOOR-TILES IN SHOWER ROOM, WALLPAPERING	2008	122,851	4,468	27.5	4,468		8,935	26
27	FIRE PROTECTION SYSTEM UNDER CANOPY	2008	12,720	462	27.5	462		1,002	27
28	INSTALL THERO PANES IN LOUNGE AND CAFETERIA	2008	2,283	83	27.5	83		180	28
29	ALZHEIMERS ROOMS-BLINDS & BORDERS	2005	1,283	46	27.5	46		97	29
30	DIG AND RUN NEW FLOOR DRAIN	2009	8,750	318	27.5	318		557	30
31	REPLACE TOILETS AND ATTACH TO NEW DRAIN	2009	3,205	116	27.5	116		165	31
32	UNILOCK BRICK/CEMENT INSTALLATION - PATIO	2009	12,139	441	27.5	441		662	32
33	REPLACE TILE, FAUCETS - 400,600,& 800 WINGS	2009	7,170	260	27.5	260		369	33
34	TOTAL (lines 1 thru 33)		$ 7,033,140	$ 174,709		$ 244,947	$ 70,238	$ 3,942,624	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,033,140	$ 174,709		$ 244,947	$ 70,238	$ 3,942,624	1
2	INSTALL NEW HOT WATER LINE TO MACHINES	2009	3,060	111	27.5	111		148	2
3	DRYWALL RESIDENT BATHROOMS	2009	5,000	181	27.5	181		242	3
4	REMOVE & INTALL TILES - RM 410,409,708,902 &								4
5	FIRST FLOOR HALLWAY	2010	4,240	141	27.5	141		141	5
6	REMOVE & INTALL TILES - RMS 802,803,301-314,502-507	2010	3,500	117	27.5	117		117	6
7	INSTALL DRYWALL IN LOUNGE AREA & KITCHEN	2010	3,700	112	27.5	112		112	7
8	NEW CAR SILL AND DOOR RESTRICTOR - FREIGHT								8
9	ELEVATOR	2010	8,173	99	27.5	99		99	9
10	REMOVE & INSTALL NEW SIDEWALK	2010	3,020	64	27.5	64		64	10
11	CUT, REMOVE & REPLACE BLACKTOP BY STORM DRAIN	2010	7,677	384	10	384		384	11
12	RUN NEW CIRCUITS FROM EMERGENCY PANEL	2010	2,350	36	27.5	36		36	12
13	INSTALL 178 SINGLE POLE 120 VOLT OUTLETS	2010	41,750	127	27.5	127		127	13
14									14
15									15
16			ADJ. TO SL	70,238			(70,238)		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	TOTAL (lines 1 thru 33)		$ 7,115,610	$ 246,319		$ 246,319	$	$ 3,944,094	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: 01/01/2010 Ending: 12/31/2010

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	$ 2,000,968	$ 171,824	$ 182,735	$ 10,911		$ 964,094	71
72	Current Year Purchases	100,122	77,283	5,006	(72,277)		5,006	72
73	Fully Depreciated Assets	219,693					219,693	73
74	RELATED PARTY		7,490	7,490				74
75	TOTALS	$ 2,320,783	$ 256,597	$ 195,231	$ (61,366)		$ 1,188,793	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	TOTALS			$	$	$	$		$	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)	$ 9,550,738	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 502,916	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 441,550	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (61,366)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,132,887	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 39,120 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2008 FORD E350	$ #######	$ 15,926	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 15,926	21

* 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.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 476,294	$		$ 476,294	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			164,043			164,043	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			609,244			609,244	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 prescrpts				201,174		201,174	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): MEDICAL SUPPLIES	39-2					103,252		103,252	13
14	TOTAL			$		$ 1,249,581	$ 304,426		$ 1,554,007	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.

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 346,432	$ 491,290	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 899,879)	1,433,012	1,433,012	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,883	1,883	5
6	Prepaid Insurance	63,055	121,420	6
7	Other Prepaid Expenses	159,082	159,082	7
8	Accounts Receivable (owners or related parties)	880	8,233	8
9	Other(specify): ESCROW DEPOSITS		196,884	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,004,344	$ 2,411,804	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		4,578,884	15
16	Equipment, at Historical Cost	2,065,040	2,065,040	16
17	Accumulated Depreciation (book methods)	(1,809,362)	(5,370,435)	17
18	Deferred Charges		35,854	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		231,131	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 255,678	$ 3,749,630	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,260,022	$ 6,161,434	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 694,815	$ 722,565	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,420	55,420	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,610	59,610	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,153	67,153	31
32	Accrued Real Estate Taxes(Sch.IX-B)		180,000	32
33	Accrued Interest Payable	2,681	22,645	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	269,432	269,432	36
37	DUE TO LESSOR/PRIOR OWNER	2,439,319		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,588,430	$ 1,376,825	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,675,658	5,532,527	39
40	Mortgage Payable		4,436,405	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)**	$ 4,675,658	$ 9,968,932	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,264,088	$ 11,345,757	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,004,066)	$ (5,184,323)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,260,022	$ 6,161,434	48

*(See instructions.)

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,993,391)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(8)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,993,399)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(158,080)	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	(25,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) SEC 754 BASIS ADJ.	172,413	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (10,667)	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)**	$ (6,004,066)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,711,711	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,711,711	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,098	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,098	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSION	260	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 260	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,741,069	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,857,042	31
32	Health Care	4,701,091	32
33	General Administration	3,402,572	33
	B. Capital Expense		
34	Ownership	1,273,294	34
	C. Ancillary Expense		
35	Special Cost Centers	1,554,007	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,899,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	(158,080)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (158,080)	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: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,921	2,103	$ 75,726	$ 36.01	1
2	Assistant Director of Nursing	2,047	2,398	80,431	33.54	2
3	Registered Nurses	29,858	33,115	970,492	29.31	3
4	Licensed Practical Nurses	32,789	35,553	945,095	26.58	4
5	CNAs & Orderlies	118,695	127,859	1,684,704	13.18	5
6	CNA Trainees					6
7	Licensed Therapist	2,419	2,840	79,695	28.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,794	4,249	66,786	15.72	9
10	Activity Assistants	5,291	5,752	60,038	10.44	10
11	Social Service Workers	3,595	3,944	64,251	16.29	11
12	Dietician					12
13	Food Service Supervisor	4,156	6,131	117,880	19.23	13
14	Head Cook	5,022	5,592	67,321	12.04	14
15	Cook Helpers/Assistants	23,346	25,221	229,373	9.09	15
16	Dishwashers					16
17	Maintenance Workers	2,129	2,429	59,525	24.51	17
18	Housekeepers	28,048	30,742	319,943	10.41	18
19	Laundry	1,892	2,360	31,197	13.22	19
20	Administrator	1,901	2,302	168,334	73.13	20
21	Assistant Administrator	1,863	2,166	56,333	26.01	21
22	Other Administrative					22
23	Office Manager	5,703	6,559	132,995	20.28	23
24	Clerical	7,435	8,305	145,270	17.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,027	4,399	120,720	27.44	31
32	Other Health C: WARD CLERKS	4,243	4,848	73,725	15.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	290,174	318,867	$ 5,549,834 *	$ 17.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	430	$ 19,374	1-3	35
36	Medical Director	96	9,000	9-3	36
37	Medical Records Consultant	25	1,558	10-3	37
38	Nurse Consultant	MONTHLY	109,444	10-3	38
39	Pharmacist Consultant	MONTHLY	9,215	10-3	39
40	Physical Therapy Consultant		0	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	41	2,950	11-3	44
45	Social Service Consultant	71	15,590	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	663	$ 167,131		49

C. CONTRACT NURSES

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

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KOHLS	ADMINISTRATOR		$ 168,334
LYNN BLACKBURN	ASST ADMIN		56,333
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 224,667

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC, LLC	$ 261,010
CHESTERFIELD, LLC	261,010
TOTAL (agree to Schedule V, line 17, col. 3)	$ 522,020
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		433,845
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 433,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 118,709
Unemployment Compensation Insurance	56,124
FICA Taxes	415,092
Employee Health Insurance	439,668
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	10,291
EMPLOYEE PHYSICAL EXAMS	4,185
PENSION/PROFIT SHARING PLANS	14,050
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,058,119

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,524
Health Care Worker Background Check	1,120
(Indicate # of checks performed 52)	
Patient Background Checks 454	4,540
TRUST/FRANCHISE/CONTRIB/ETC	10,119
MARKETING/ADV/PROMO	103,249
LICENSES/DUES/SUBSCRIPTIONS	20,593
MGMT CO ALLOC	725
TRUST/FRANCHISE/CONTRIB/ETC	(10,119)
Less: Public Relations Expense	(68,422)
Non-allowable advertising	(8,036)
Yellow page advertising	(26,791)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,502

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	355
RELATED PARTY	16,997
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,352

**See instructions.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. - $17831.25**

(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. $ **43,231** 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.