FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0050708

Facility Name: Countryside Nursing & Rehab Center

Address: 1635 East 154th Street (Number) Dolton (City) 60419 (Zip Code)

County: Cook

Telephone Number: (708) 841-9550 **Fax #** (708) 841-4517

HFS ID Number:

Date of Initial License for Current Owners: 12/16/2009

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	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		354	3,771	4,125	8
9	SNF/PED					9
10	ICF	59,364	453	21	59,838	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,364	807	3,792	63,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.95%

D. How many bed-hold days during this year were paid by the Department?
None (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 11/1/90

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 100 and days of care provided 3,771

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	222,084	33,314	11,271	266,669		266,669	3,891	270,560			1
2	Food Purchase		306,582		306,582		306,582	424	307,006			2
3	Housekeeping	195,714	39,991		235,705		235,705	661	236,366			3
4	Laundry	69,296	11,987		81,283		81,283	(130)	81,153			4
5	Heat and Other Utilities			139,584	139,584		139,584	1,488	141,072			5
6	Maintenance	127,259	110	83,244	210,613		210,613	12,341	222,954			6
7	Other (specify):*							2,080	2,080			7
8	**TOTAL General Services**	614,353	391,984	234,099	1,240,436		1,240,436	20,755	1,261,191			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	1,911,679	51,181	11,573	1,974,433		1,974,433	31,309	2,005,742			10
10a	Therapy	98,332		293	98,625		98,625	4,574	103,199			10a
11	Activities	109,172	2,021	624	111,817		111,817		111,817			11
12	Social Services	352,111	23,444	12,902	388,457		388,457	3,273	391,730			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,765	5,765			15
16	**TOTAL Health Care and Programs**	2,471,294	76,646	52,392	2,600,332		2,600,332	44,921	2,645,253			16
	C. General Administration											
17	Administrative	300,012			300,012		300,012	58,698	358,710			17
18	Directors Fees											18
19	Professional Services			431,864	431,864	(6,484)	425,380	(263,068)	162,312			19
20	Dues, Fees, Subscriptions & Promotions			20,287	20,287		20,287	(3,998)	16,289			20
21	Clerical & General Office Expenses	68,903	14,430	250,899	334,232		334,232	(34,715)	299,517			21
22	Employee Benefits & Payroll Taxes			433,233	433,233		433,233	(10,387)	422,846			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,954	1,954		1,954	1,736	3,690			24
25	Other Admin. Staff Transportation			4,088	4,088		4,088	845	4,933			25
26	Insurance-Prop.Liab.Malpractice			135,700	135,700		135,700	1,106	136,806			26
27	Other (specify):*							34,029	34,029			27
28	**TOTAL General Administration**	368,915	14,430	1,278,025	1,661,370	(6,484)	1,654,886	(215,754)	1,439,132			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,454,562	483,060	1,564,516	5,502,138	(6,484)	5,495,654	(150,078)	5,345,576			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Countryside Nursing & Rehab Center #0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			971	971		971	209,414	210,385			30
31	Amortization of Pre-Op. & Org.			627	627		627	(627)				31
32	Interest			35,612	35,612		35,612	591,310	626,922			32
33	Real Estate Taxes			431,992	431,992	6,484	438,476	2,156	440,632			33
34	Rent-Facility & Grounds			736,312	736,312		736,312	(734,977)	1,335			34
35	Rent-Equipment & Vehicles			47,613	47,613		47,613	2,393	50,006			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,253,127	1,253,127	6,484	1,259,611	69,669	1,329,280			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		199,409	307,385	506,794		506,794	(104,092)	402,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,858	107,858		107,858		107,858			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		199,409	415,243	614,652		614,652	(104,092)	510,560			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,454,562	682,469	3,232,886	7,369,917		7,369,917	(184,500)	7,185,417			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	55,657	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,257)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,000)	21		24
25	Fund Raising, Advertising and Promotional	(7,680)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(51,400)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,718)		$	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)	6,218		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,218		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (184,500)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Countryside Nursing & Rehab Center

ID# 0050708

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Interest Income	$ (42)	32	1
2	Patient Clothing	(52)	10	2
3	Theft Loss	(1,102)	21	3
4	Collection Expense	(377)	21	4
5	Pharmacy Veterans	(160)	10	5
6	Non-Allowable Amortization	(627)	31	6
7	Building Co- Bank Service Fee	(193)	21	7
8	Building Co-Filing Fees	(400)	21	8
9	Building Co-Loan Fee	(5,518)	21	9
10	Building Co-Amortization	(36,717)	36	10
11	Non-Allowable Legal	(3,398)	19	11
12	Non-Allowable Professional Fees	(1,239)	19	12
13	Non-Allowable Promotion	(1,575)	19	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**	(51,400)		49

Countryside Nursing & Rehab Center

ID# 0050708

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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			166		4,916		(1,191)					3,891	1
2	Food Purchase	(39)		463									424	2
3	Housekeeping			595		66							661	3
4	Laundry									(130)			(130)	4
5	Heat and Other Utilities			1,350		138							1,488	5
6	Maintenance			3,880	8,324	137							12,341	6
7	Other (specify):*				1,391	689							2,080	7
8	**TOTAL General Services**	(39)		6,454	9,715	5,946		(1,191)		(130)			20,755	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(212)				31,632				(111)			31,309	10
10a	Therapy					4,574							4,574	10a
11	Activities													11
12	Social Services					3,273							3,273	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,533	232						5,765	15
16	**TOTAL Health Care and Programs**	(212)				45,012	232			(111)			44,921	16
	C. General Administration													
17	Administrative			2,749	10,678	45,271							58,698	17
18	Directors Fees													18
19	Professional Services	(6,212)		(217,413)		(39,443)							(263,068)	19
20	Fees, Subscriptions & Promotions	(7,680)		3,486		196							(3,998)	20
21	Clerical & General Office Expenses	(194,847)	6,111	16,287	129,420	8,314							(34,715)	21
22	Employee Benefits & Payroll Taxes				(9,979)		(232)			(176)			(10,387)	22
23	Inservice Training & Education													23
24	Travel and Seminar			170		1,566							1,736	24
25	Other Admin. Staff Transportation			845									845	25
26	Insurance-Prop.Liab.Malpractice			928		178							1,106	26
27	Other (specify):*				26,776	7,253							34,029	27
28	**TOTAL General Administration**	(208,739)	6,111	(192,948)	156,895	23,335	(232)			(176)			(215,754)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(208,990)	6,111	(186,494)	166,610	74,293		(1,191)		(417)			(150,078)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Countryside Nursing & Rehab Center** **#** **0050708** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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	**55,657**	**147,798**	**5,012**		**947**							**209,414**	**30**
31	Amortization of Pre-Op. & Org.	**(627)**											**(627)**	**31**
32	Interest	**(42)**	**563,719**	**9,566**		**18,067**							**591,310**	**32**
33	Real Estate Taxes			**1,942**		**214**							**2,156**	**33**
34	Rent-Facility & Grounds		**(736,312)**	**1,335**									**(734,977)**	**34**
35	Rent-Equipment & Vehicles			**2,393**									**2,393**	**35**
36	Other (specify):*	**(36,717)**	**36,717**											**36**
37	**TOTAL Ownership**	**18,271**	**11,922**	**20,248**		**19,228**							**69,669**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers							**(267)**	**(103,768)**	**(57)**			**(104,092)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*													**43**
44	**TOTAL Special Cost Centers**							**(267)**	**(103,768)**	**(57)**			**(104,092)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(190,718)**	**18,033**	**(166,246)**	**166,610**	**93,521**		**(1,458)**	**(103,768)**	**(474)**			**(184,500)**	**45**

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		See Attached		See Attached		
				Countryside Healthcare Center		Building Co.

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	Rental Income-Base	$ 736,312	Countryside Healthcare Center, LLC	100.00%	$	$ (736,312)	1
2	V	33	Rental Income-Property Taxes	431,993	Countryside Healthcare Center, LLC	100.00%	134,188	(297,805)	2
3	V	21	Bank Service Fee		Countryside Healthcare Center, LLC	100.00%	193	193	3
4	V	21	Filing Fees		Countryside Healthcare Center, LLC	100.00%	400	400	4
5	V	30	Depreciation Expense		Countryside Healthcare Center, LLC	100.00%	147,798	147,798	5
6	V	36	Amortization Expense		Countryside Healthcare Center, LLC	100.00%	36,717	36,717	6
7	V	33	Real Estate Taxes		Countryside Healthcare Center, LLC	100.00%	297,805	297,805	7
8	V	32	Interest Expense		Countryside Healthcare Center, LLC	100.00%	563,719	563,719	8
9	V	21	Loan Fees		Countryside Healthcare Center, LLC	100.00%	5,518	5,518	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,168,305			$ 1,186,338	$ * 18,033	14

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 166	$ 166	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	463	463	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	595	595	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,350	1,350	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,880	3,880	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,749	2,749	20
21	V	19	Professional Fees	215,608	Extended Care Consulting, LLC	100.00%	11,462	(217,413)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,486	3,486	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,287	16,287	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	170	170	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	845	845	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	928	928	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	5,012	5,012	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	9,566	9,566	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,942	1,942	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	1,335	1,335	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,393	2,393	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,608			$ 62,629	$ * (166,246)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,324	$ 8,324	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,391	1,391	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)	12,902	Extended Care Consulting, LLC	100.00%	12,902		19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	10,678	10,678	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	129,420	129,420	22
23	V	21	Office and Clerical (Direct)	24,207	Extended Care Consulting, LLC	100.00%	24,207		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,411	23,411	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,365	3,365	25
26	V	22	Employee Benefits	9,979	Extended Care Consulting, LLC	100.00%		(9,979)	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			$ 47,088			$ 213,698	$ * 166,610	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 66	$ 66	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	138	138	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	137	137	17
18	V	19	Professional Fees	53,275	Extended Care Clinical, LLC	100.00%	7,682	(39,443)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	196	196	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,834	1,834	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,566	1,566	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	178	178	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	947	947	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	18,067	18,067	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	214	214	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,916	4,916	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	689	689	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	31,632	31,632	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	4,574	4,574	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	3,273	3,273	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,533	5,533	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	45,271	45,271	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,480	6,480	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,253	7,253	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,275			$ 140,646	$ * 93,521	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	2,130	Extended Care Clinical, LLC	100.00%	2,130		17
18	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%			18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	232	232	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	232	Extended Care Clinical, LLC	100.00%		(232)	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			$ 2,362			$ 2,362	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1	Dietary Supplies, Supplements	$ 2,682	Care Centers Health Systems, Inc.	100.00%	$ 1,491	$ (1,191)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	601	Care Centers Health Systems, Inc.	100.00%	334	(267)	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			$ 3,283			$ 1,825	$ * (1,458)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	39	Therapy	$ 307,385	TriCare Rehab	100.00%	$ 203,617	$ (103,768)	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			$ 307,385			$ 203,617	$ * (103,768)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping		Xcel Supply, LLC	100.00%			16
17	V	4	Laundry	1,950	Xcel Supply, LLC	100.00%	1,820	(130)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	1,669	Xcel Supply, LLC	100.00%	1,558	(111)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	2,637	Xcel Supply, LLC	100.00%	2,461	(176)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	851	Xcel Supply, LLC	100.00%	794	(57)	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			$ 7,107			$ 6,633	$ * (474)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 54,441	$ 54,441	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	54,441	CCS Employee Benefits Group	100.00%		(54,441)	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			$ 54,441			$ 54,441	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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			$			$	$	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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Eric Rothner	Shareholder	Administrative	90.00%	See Attached	1.38	2.97%	Mgmt. Fees	$		1
2	Mark Steinberg	Relative	Administrative		See Attached	2.33	4.24%	Al. Salary/Fees	6,762	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	0.29	0.73%	Alloc. Salary	500	22-7	3
4	G. Matt Silvers	Relative	Administrative		See Attached	0.01	0.04%	Alloc. Salary	42	17-7	4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										9
10	IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 7,304		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 Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	63,963	$ 166	1
2	02	Food	Patient Days	1,512,273	34	10,940		63,963	463	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		63,963	595	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		63,963	1,350	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		63,963	3,880	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		63,963	2,749	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		63,963	11,462	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		63,963	3,486	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		63,963	16,287	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		63,963	170	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		63,963	845	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		63,963	928	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		63,963	5,012	13
14	32	Interest	Patient Days	1,512,273	34	226,162		63,963	9,566	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		63,963	1,942	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		63,963	1,335	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		63,963	2,393	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 62,629	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	63,963	8,324	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		63,963	1,391	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607				4
5	12	Admission (Direct)	Direct		34	52,036	52,036		12,902	5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	63,963	10,678	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	63,963	129,420	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		24,207	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		63,963	23,411	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			3,365	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					$ 5,054,827	$ 4,364,695		$ 213,698	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	63,963	$ 66	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		63,963	138	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		63,963	137	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		63,963	7,682	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		63,963	196	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		63,963	1,834	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		63,963	1,566	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		63,963	178	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		63,963	947	9
10	32	Interest	Patient Days	1,512,273	34	427,165		63,963	18,067	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		63,963	214	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	63,963	4,916	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		63,963	689	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	63,963	31,632	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	63,963	4,574	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	63,963	3,273	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		63,963	5,533	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	63,963	45,271	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	63,963	6,480	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		63,963	7,253	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 140,646	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		2,130	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597			4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			232	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 2,362	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	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	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 1,491	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						334	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,825	25

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	39	Therapy	Direct Allocation			$	$		$ 203,617	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 203,617	25

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	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	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation							2
3	4	Laundry	Direct Allocation						1,820	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						1,558	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						2,461	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						794	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					$	$		$ 6,633	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 54,441	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 54,441	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Lake Forest		X	Mortgage			$	$ 7,351,629			$ 563,719	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	HFG		X	Line of Credit							(6,706)	6
7	First Bank										31,544	7
8	See Supplemental Schedule										33,246	8
9	TOTAL Facility Related						$	$ 7,351,629			$ 621,803	9
	B. Non-Facility Related*											
10	Paid by Oak Park		X								5,161	10
11	Interest Income		X								(42)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 5,119	14
15	TOTALS (line 9+line14)						$	$ 7,351,629			$ 626,922	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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 Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9	Homewood Loan		X								5,613	9
10	Alloc from Ext Care Conslt, Inc		X								9,566	10
11	Alloc from Ext Care Clinical		X								18,067	11
12												12
13												13
14	TOTAL Working Capital										33,246	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Nursing & Rehab Center # 0050708 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	465,977	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.)	$	441,294	2
3. Under or (over) accrual (line 2 minus line 1).	$	(24,683)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	458,831	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.	$	6,484	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.	$	440,632	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	495,354	8
	2006	480,009	9
	2007	521,160	10
	2008	569,541	11
	2009	439,138	12

2010 Accrual = $436,982 X 1.05 = $458,831

Allocation from Extended Care Consulting Building Alloc. $1,942

Allocation from Extended Care Clinical Building Alloc. $214

	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 Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050708

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.	29-13-100-001-0000	Long Term Care Property	$ 436,981.96	$ 436,981.96
2.	See Attached	Alloc from Main LLC	$ 116,500.56	$ 2,205.38
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 553,482.52	$ 439,187.34

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? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050708

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,547 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [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 [X] (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).

N/A

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	Facility	132,928	1998	$ 392,750	1
2	Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main			15,522	2
3	TOTALS	132,928		$ 408,272	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1991	24,648		20	782	782	15,527	9
10	Various			1992	28,172		20	894	894	16,585	10
11	Various			1993	11,940		20	337	337	6,254	11
12	Various			1994	4,878		20	125	125	2,044	12
13	Various			1995	34,004		20	972	972	21,710	13
14	Various			1996	20,232		20	519	519	7,526	14
15	Various			1997	17,236		20	442	442	5,970	15
16	Various			1998	13,979		20	358	358	4,513	16
17	Various			1999	33,838		20	868	868	9,873	17
18	Various			2000	18,955		20	574	574	6,217	18
19	Various			2001	8,806		20	345	345	3,207	19
20	Various			2003	136,685		20	5,095	5,095	38,580	20
21	Various			2004	49,614		20	1,860	1,860	11,487	21
22	Various			2005	80,983		20	2,945	2,945	17,527	22
23	Various			2006	65,138		20	2,520	2,520	11,415	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

*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 Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		5,553,425	147,798		148,507	709	1,750,907	67
68	Related Party Allocations (Pages 12H & 12I)		62,560	4,258		4,258		29,818	68
69	Financial Statement Depreciation			971			(971)		69
70	TOTAL (lines 4 thru 69)		$ 6,165,093	$ 153,027		$ 171,401	$ 18,374	$ 1,959,160	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 6,165,093	$ 153,027		$ 171,401	$ 18,374	$ 1,959,160	1
2	Parking Lot Improvement - Asphalt	2007	20,500		20	1,367	1,367	5,126	2
3	Cubicle Curtains - Resident Rooms & Bathrooms	2007	13,978		20	2,236	2,236	13,978	3
4	Install Corridor Doors, Hinges, & Closers	2007	3,420		20	124	124	419	4
5	Install New Air Condition Unit - Computer Room	2007	2,531		20	405	405	2,531	5
6	Replace Fedder Roof Top Unit In Dining Room	2007	5,739		20	209	209	705	6
7	Replaced Shower Stalls In A-B Wing	2008	3,714		20	186	186	478	7
8	Installation Of Anti-Freeze Loop	2008	7,995		20	400	400	884	8
9	Installation Of Fire Alarm Devices	2008	4,500		20	225	225	498	9
10	Installed Generator & Transfer Switch	2008	53,752		20	2,688	2,688	5,456	10
11	Installed New Furnace In The A-B Wing	2008	4,125		20	206	206	642	11
12	Asphalt Repairs-Front & Rear Lots	2010	5,000		20	250	250	250	12
13	7 Air Conditioning Units	2010	3,569		20	178	178	178	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	TOTAL (lines 1 thru 33)		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,293,916	$ 153,027		$ 179,875	$ 26,848	$ 1,990,305	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Building Company Information								1
2	Buildings:								2
3	Countryside Healthcare Center	1977	5,302,525	147,798	39	135,962	(11,836)	1,750,907	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2001	250,900		20	12,545	12,545		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 5,553,425	$ 147,798		$ 148,507	$ 709	$ 1,750,907	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting, 2201 Main LLC	2002	19,268	494	39	494		4,097	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	2,123	54	39	54		451	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	195	10	20	10		39	9
10	Allocated from Extended Care Consulting	2009	116	6	20	6		12	10
11	Allocated from Extended Care Consulting	2010	1,141	57	20	57		57	11
12									12
13	Allocated from Extended Care Consulting, 2201 Main LLC	2002	15,917	1,455	20	1,455		10,197	13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2003	18,758	1,714	20	1,714		12,016	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2005	932	99	20	99		435	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2009	168	8	20	8		17	16
17									17
18	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	1,754	160	20	160		1,123	18
19	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	2,066	189	20	189		1,324	19
20	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	103	11	20	11		48	20
21	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	19	1	20	1		2	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 62,560	$ 4,258		$ 4,258	$	$ 29,818	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 308,194	$ 955	$ 27,188	$ 26,233	10	$ 243,339	71
72	Current Year Purchases	6,117	62	612	550	10	612	72
73	Fully Depreciated Assets	632,017				10	632,017	73
74								74
75	TOTALS	$ 946,328	$ 1,017	$ 27,800	$ 26,783		$ 875,968	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		Dodge Ram BR 150	2006	$ 10,132	$	$ 2,026	$ 2,026	5	$ 10,130	76
77		Allocated From EC Consulting	2010	13,601	212	212		5	13,176	77
78		Allocated From EC Clinical	2010	2,364	473	473		5	1,103	78
79										79
80	TOTALS			$ 26,097	$ 685	$ 2,711	$ 2,026		$ 24,409	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,674,613	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,729	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,386	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,657	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,890,682	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 Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Allocated from Extended Care Consulting, LLC				1,335			5
6								6
7	TOTAL				$ 1,335 **			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 ☒ NO
16. Rental Amount for movable equipment: $ 31,219 Description: See Attached Schedule
(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	Facility	Infiniti M35X	$	$ 5,989	17
18	Facility	Chevy E35P		12,799	18
19					19
20					20
21	TOTAL		$	$ 18,788	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 145,513	$		$ 145,513	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,636			2,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			159,236			159,236	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				159,341		159,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						40,068		40,068	13
14	TOTAL			$		$ 307,385	$ 199,409		$ 506,794	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	$	$ 27,025	1
2	Cash-Patient Deposits	38,165	38,165	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,223,678	1,223,678	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,393	74,393	6
7	Other Prepaid Expenses	26,413	26,413	7
8	Accounts Receivable (owners or related parties)	690,022	975,461	8
9	Other(specify): See Attached Schedule	2,285,404	4,569,380	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,338,075	$ 6,934,515	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		392,750	13
14	Buildings, at Historical Cost		5,663,750	14
15	Leasehold Improvements, at Historical Cost	5,000	5,000	15
16	Equipment, at Historical Cost	9,069	403,069	16
17	Accumulated Depreciation (book methods)	(971)	(2,230,647)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,520	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(438,749)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	5,320	508,820	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,418	$ 4,405,513	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,356,493	$ 11,340,028	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,088,079	$ 1,088,078	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	79,162	79,162	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	267,235	267,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,938	488,769	31
32	Accrued Real Estate Taxes(Sch.IX-B)	458,831	458,831	32
33	Accrued Interest Payable		33,695	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	303,011	306,511	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,226,256	$ 2,722,281	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,351,629	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,351,629	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,226,256	$ 10,073,910	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,130,237	$ 1,266,118	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,356,493	$ 11,340,028	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 261,147	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 261,147	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,869,090	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,869,090	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)**	$ 2,130,237	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 9,168,404	1
2	Discounts and Allowances for all Levels	(958,701)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,209,703	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	898,014	6
7	Oxygen	1,506	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 899,520	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	129,464	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	278	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 129,742	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,239,007	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,240,436	31
32	Health Care	2,600,332	32
33	General Administration	1,661,370	33
	B. Capital Expense		
34	Ownership	1,253,127	34
	C. Ancillary Expense		
35	Special Cost Centers	506,794	35
36	Provider Participation Fee	107,858	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,369,917	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,869,090	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,869,090	43

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

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

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

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

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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	1,733	2,347	$ 93,444	$ 39.81	1
2	Assistant Director of Nursing	1,949	2,126	72,342	34.03	2
3	Registered Nurses	19,936	21,973	583,802	26.57	3
4	Licensed Practical Nurses	23,213	24,572	547,758	22.29	4
5	CNAs & Orderlies	55,858	63,386	598,060	9.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,385	6,120	98,332	16.07	8
9	Activity Director	1,989	2,323	32,695	14.07	9
10	Activity Assistants	7,444	8,531	76,477	8.96	10
11	Social Service Workers	18,923	20,122	352,111	17.50	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,223	40,496	18.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,832	19,481	181,588	9.32	15
16	Dishwashers					16
17	Maintenance Workers	9,801	10,727	127,259	11.86	17
18	Housekeepers	20,104	22,324	195,714	8.77	18
19	Laundry	6,693	7,864	69,296	8.81	19
20	Administrator	1,885	2,418	123,643	51.13	20
21	Assistant Administrator	1,941	2,086	56,369	27.02	21
22	Other Administrative	2,080	2,080	120,000	57.69	22
23	Office Manager					23
24	Clerical	3,959	4,383	68,903	15.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,658	1,838	16,273	8.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	203,316	226,924	$ 3,454,562 *	$ 15.22	34

SEE ACCOUNTANTS' COMPILATION REPORT

* 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	221	$ 11,271	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant	16	768	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,675	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	293	10-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	624	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	See Attached	583	15,032		48
49	TOTAL (lines 35 - 48)	837	$ 63,663		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joeann Brew	Administrator	0.00%	$ 123,643
Mila J Jeffrey	Asst. Admin	0.00%	56,369
Sherwin Ray	Other Admin	0.00%	120,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 300,012

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick, Bokor, Kagda	Accounting	$ 28,650
Denise Carnes	Accounting	3,083
Personnel Planners	Unemployment Consult	2,170
Prospect Resources	Natural Gas Procurement	1,500
Richard Peelo	Medicare Cost Report	4,800
Ron Cornaya	Accounting	500
Alan Sorscher	Accounting	500
HFG	Line of Credit Audit	53,470
Extended Care Consulting	Home Office Expense	215,608
Extended Care Clinical	Home Office Expense	53,275
3 C Healthcare Consulting	Risk Management	2,545
See Supplemetal Schedule		65,762
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 431,864

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,171
Unemployment Compensation Insurance	42,975
FICA Taxes	247,527
Employee Health Insurance	40,575
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emplyee Physicals	2,952
Holiday Expense	1,600
Other Employee Welfare	1,047
TOTAL (agree to Schedule V, line 22, col.8)	$ 422,847

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,820
Advertising: Employee Recruitment	7,288
Health Care Worker Background Check	2,302
(Indicate # of checks performed 136)	
Patient Background Checks	
Dues & Subscriptions	13
Licenses, Inspections & Permits	1,184
Advertising & Promotions	7,680
Alloc from Extended Care Consulting	3,486
See Supplemental Schedule	196
Less: Public Relations Expense	( )
Non-allowable advertising	(7,680)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,290

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,954
Allocated From EC Consulting	170
Allocated From EC Clinical	1,566
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,690

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nursing & Rehab Center # 0050708 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(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 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,777** 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. **N/A**

(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. $ **107,858**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
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: **N/A**

(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.