FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0051763

Facility Name: Countryside Care Centre

Address: 2330 W Galena Blvd (Number) Aurora (City) 60506 (Zip Code)

County: Kane

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

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2014 to 12/31/2014 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)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 N/A

	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	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			11,201	11,201	8
9	SNF/PED					9
10	ICF	46,646	4,312	6,118	57,076	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,646	4,312	17,319	68,277	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.15%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 127 and days of care provided 6,848

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	409,783	38,425	21,510	469,718		469,718		469,718			1
2	Food Purchase		424,202		424,202		424,202		424,202			2
3	Housekeeping	257,052	73,328		330,380		330,380		330,380			3
4	Laundry	84,687	33,378	11,916	129,981		129,981		129,981			4
5	Heat and Other Utilities			272,940	272,940		272,940	838	273,778			5
6	Maintenance	57,287	1,657	166,475	225,419		225,419	7,714	233,133			6
7	Other (specify):*											7
8	TOTAL General Services	808,809	570,990	472,841	1,852,640		1,852,640	8,552	1,861,192			8
	B. Health Care and Programs											
9	Medical Director			21,090	21,090		21,090		21,090			9
10	Nursing and Medical Records	4,202,671	272,298	15,436	4,490,405		4,490,405	63,265	4,553,670			10
10a	Therapy	186,905			186,905		186,905		186,905			10a
11	Activities	131,625		11,127	142,752		142,752		142,752			11
12	Social Services	94,135		284	94,419		94,419		94,419			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,639	12,639			15
16	TOTAL Health Care and Programs	4,615,336	272,298	47,937	4,935,571		4,935,571	75,904	5,011,475			16
	C. General Administration											
17	Administrative	185,192		724,333	909,525		909,525	(724,333)	185,192			17
18	Directors Fees											18
19	Professional Services			311,521	311,521		311,521	7,552	319,073			19
20	Dues, Fees, Subscriptions & Promotions			40,477	40,477		40,477	(2,573)	37,904			20
21	Clerical & General Office Expenses	222,196	39,265	97,834	359,295		359,295	259,420	618,715			21
22	Employee Benefits & Payroll Taxes			1,078,943	1,078,943		1,078,943		1,078,943			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,883	6,883		6,883	18,712	25,595			24
25	Other Admin. Staff Transportation			7,661	7,661		7,661	(2,956)	4,705			25
26	Insurance-Prop.Liab.Malpractice			482,234	482,234		482,234	10,452	492,686			26
27	Other (specify):* Mgmt alloc of benef							36,826	36,826			27
28	TOTAL General Administration	407,388	39,265	2,749,886	3,196,539		3,196,539	(396,900)	2,799,639			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,831,533	882,553	3,270,664	9,984,750		9,984,750	(312,444)	9,672,306			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Countryside Care Centre #0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			169,735	169,735		169,735	5,301	175,036			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,864	109,864		109,864	(5,733)	104,131			32
33	Real Estate Taxes			78,796	78,796		78,796	16,312	95,108			33
34	Rent-Facility & Grounds			1,534,470	1,534,470		1,534,470	(167,066)	1,367,404			34
35	Rent-Equipment & Vehicles			83,454	83,454		83,454	4,673	88,127			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,976,319	1,976,319		1,976,319	(146,513)	1,829,806			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			24,882	24,882		24,882		24,882			38
39	Ancillary Service Centers		289,289	1,667,160	1,956,449		1,956,449		1,956,449			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			484,017	484,017		484,017		484,017			42
43	Other (specify):* **Non-Allowable Cos**			371,731	371,731		371,731	(371,731)				43
44	**TOTAL Special Cost Centers**		289,289	2,547,790	2,837,079		2,837,079	(371,731)	2,465,348			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,831,533	1,171,842	7,794,773	14,798,148		14,798,148	(830,688)	13,967,460			45

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(19,819)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,733)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,678)	43		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	(5,197)	43		18
19	Entertainment				19
20	Contributions	(5,499)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(241,443)	43		24
25	Fund Raising, Advertising and Promotional	(12,155)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,259)	43		28
29	Other-Attach Schedule See Page 5A	(101,866)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (395,649)		$	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)	(435,039)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (435,039)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (830,688)		37

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

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

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

Countryside Care Centre

ID# 0051763

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (46,273)	43	1
2	Laboratory Costs	(17,632)	43	2
3	X-Ray Costs	(18,615)	43	3
4	Lobbying Expense	(6,712)	20	4
5	Medicare and Medicare HMO ancillary costs	(1,161)	43	5
6	Nonallowable Legal	(8,516)	19	6
7	Nonallowable other staff & admin transportation	(2,956)	25	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(101,866)		49

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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 [X] 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			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 838	$ 838	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	7,714	7,714	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	63,265	63,265	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	12,639	12,639	18
19	V	17	Administrative	724,333	Symphony Financial Services, LLC	100.00%		(724,333)	19
20	V	19	Professional Services		Symphony Financial Services, LLC	100.00%	32,380	32,380	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	4,139	4,139	21
22	V	21	Clerical & General Office Exp		Symphony Financial Services, LLC	100.00%	259,421	259,421	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	18,712	18,712	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	10,452	10,452	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	36,826	36,826	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	5,301	5,301	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(167,066)	(167,066)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	4,673	4,673	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			$ 724,333			$ 289,294	$ * (435,039)	39

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Crestwood, LLC D/B/A Symphony o	Crestwood	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				5
6	Rena Dickman	4.50	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				6
7	Robert Hartman	4.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				7
8	Jack Hartman	3.00						8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	NuCare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	No owners receive compensation from this facility.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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: Symphony Financial Services, LLC
Street Address: 7257 N. Lincoln Ave,
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((847) 933-2600
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	5	Utilities	Occupied Bed Days	418,769	8	$ 5,138	$	68,277	$ 838	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		68,277	7,714	2
3	10	Nursing & Med Records - Sal	Occupied Bed Days	418,769	8	388,030	388,030	68,277	63,265	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		68,277	12,639	4
5	19	Professional Services-Legal	Occupied Bed Days	418,769	8	14,326		68,277	2,336	5
6	19	Professional Services-Other	Occupied Bed Days	418,769	8	184,271		68,277	30,044	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		68,277	4,139	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	68,277	242,978	8
9	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	100,854		68,277	16,443	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		68,277	18,712	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		68,277	10,452	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		68,277	36,826	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		68,277	5,301	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		68,277	(167,066)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		68,277	2,816	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		68,277	1,857	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 1,878,306		$ 289,294	25

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Capital Improvements	Interest Only	12/30/2011	2,000,000	222,032	12/30/2017	0.0525	9,775	6
7	The Private Bank		X	Line of credit	Interest Only	12/30/2011	27,000,000	2,273,389	12/30/2015	0.0450	100,089	7
8												8
9	TOTAL Facility Related						$ 29,000,000	$ 2,495,421			$ 109,864	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(5,733)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,733)	14
15	TOTALS (line 9+line14)						$ 29,000,000	$ 2,495,421			$ 104,131	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.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 241,800	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.)	2013	$ 156,396	2
3. Under or (over) accrual (line 2 minus line 1).		$ (85,404)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 164,200	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.)		$ 16,312	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.		$ 95,108	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	171,414	8
	2010	178,035	9
	2011	203,590	10
	2012	230,275	11
	2013	156,396	12

2013 Tax Accrual = $156,396 * 1.05 = $164,215.80, use $164,200

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Care Centre COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0051763

CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	Nursing Home	$ 156,396.04	$ 156,396.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 156,396.04	$ 156,396.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Architectural fees, contractor fees, paint, remove wallpaper,			2013	198,047	9,903	20	9,903		16,805	9
10	install flooring, demo, carpentry, drywall, install wallpaper										10
11	First Floor										11
12	Demo/carpentry/drywall, acoustical ceiling, interior electrical			2013	116,913	5,845	20	5,845		9,919	12
13	alarms, painting, wall covering, floor covering, add 3 heads										13
14	contractor fees - First Floor and Dining Room										14
15	Interior painting, replace storefront glass, wall and floor			2013	22,173	1,108	20	1,108		1,780	15
16	coverings - First Floor										16
17	Repiped water line to 3 compartments			2013	2,630	131	20	131		203	17
18	Demo/carpentry/drywall, permit, contractor fees - First Floor			2013	54,915	2,746	20	2,746		4,410	18
19	Interior electrical alarms			2013	16,460	823	20	823		1,322	19
20	Exterior demo/carpentry, interior elec/alarms, plumbing,			2013	50,619	2,531	20	2,531		3,912	20
21	open office, engineering - First Floor & Dining Room										21
22	Carpet removal - Nurses station tie back in all vct			2013	10,856	543	20	543		839	22
23	Roofing			2013	10,000	500	20	500		773	23
24	Lounge 500 - New Carpet			2013	3,100	443	7	443		738	24
25	Demo/carpentry/drywall, electrical, glass, demo brick &			2013	303,589	15,180	20	15,180		21,270	25
26	rebuild around windows, engineering, besam swing door,										26
27	painting, modified, bitumen, ridge vent, aluminum soffit										27
28	architecture fees, stucco molding, contractors fees -										28
29	First Floor, Spa Room, Rear Entry Vestibule, Exterior of Building										29
30	Fencing in patio			2013	2,922	195	15	195		276	30
31	Electircal work for office			2013	4,391	220	20	220		273	31
32	Demo/carpentry/drywall, window wall tape & mud, saw cut			2013	49,040	2,452	20	2,452		2,898	32
33	concrete, excavation, rough in & frame roof & rear vestibule,										33
34	steel posts, besam swing door, contractors fees - Rear Vestibule										34
35	& Second Floor										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 Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Painting/Carpentry - Entry & Second Floor	2013	13,180	1,883	7	1,883		2,354	37
38	Demo/Carpentry/Drywall, exterior demo, emergency	2013	53,564	2,678	20	2,678		2,840	38
39	power, electrical, gen cont fees-Entryway & Second Floor								39
40	Painting/Carpentry - Office & Back Entrance	2013	1,980	282	7	282		306	40
41	Roof Garden	2013	8,595	573	15	573		621	41
42									42
43	Facility Remodeling	2014	85,002	3,651	5-20	3,651		3,651	43
44	- Custom Hollow Metal Doors & Frames: Entrance								44
45	- Exterior Demo & Carpentry								45
46	- General Contracting								46
47	- Architecture Fees								47
48	- Install & Wire 2 Light Poles & Replace Ballards								48
49	- Interior Painting of Door Jambs & 3 Hallways								49
50	- Supplied & Installed Metal Flashing, Flat Roof, and								50
51	Cement Roof on 2nd Floor								51
52	- Sealcoating Parking Lot								52
53	- Bipart Slide Door								53
54	- Repair and Install Grease Interceptor: Kitchen								54
55	- Enclose Top of W/Drywall in Closet: Resident Rooms								55
56	- Remove Vent and Install Piece of Sheet Metal in closets								56
57	- Tape and Install FRP								57
58	- Provide Door Coordinators on 8 doors								58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,007,975	$ 51,683		$ 51,683	$	$ 75,190	70

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 649,343	$ 108,500	$ 108,500	$	5-7	$ 226,189	71
72	Current Year Purchases	59,511	7,893	7,893		5-7	7,893	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	28,999		5,301	5,301	5-7	7,958	74
75	TOTALS	$ 737,853	$ 116,393	$ 121,694	$ 5,301		$ 242,040	75

D. Vehicle Costs. (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	Patient Transportation	2008 Ford Van	2013	$ 16,587	$ 1,659	$ 1,659	$	10	$ 2,903	76
77										77
78										78
79										79
80	TOTALS			$ 16,587	$ 1,659	$ 1,659	$		$ 2,903	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)	$ 1,762,415	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,735	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 175,036	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,301	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 320,133	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC
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. [X] 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:	1972	203	12/31/2011	$ 1,531,151	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(167,066)			6
7	TOTAL		203		$ 1,364,085 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,319
   This amount was calculated by dividing the total amount to be amortized 33,198
   by the length of the lease 10 .

9. Option to Buy: [ ] YES [X] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning 12/31/2011
    Ending 12/31/2021

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$ 1,122,000
13.	/2016	$ 1,144,440
14.	/2017	$ 1,167,329

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 86,077 Description: See Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2014 Acura MDX	$ 193.23	$ 193	17
18					18
19					19
20	Allocated from Mgmt. Co.			1,857	20
21	TOTAL		$ 193.23	$ 2,050	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name: **Countryside Care Centre**
IDPH License ID Number: **0051763**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Wound Pressure Pump	6,231
Oxygen Concentrator	15,124
Bipap	8,283
Bed Bariatric	6,512
Mattress 36in	171
Water machine	132
Blood Pressure Machine	2,376
Coolers	4,950
Ice Machine	4,440
Aquarium service lease	2,634
Ricoh	30,326
Prorated Voice Media	438
Mailing Machine	1,644
Home Office Alloc	2,816
Total - Line 16	**86,077**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

It is the policy of this facility to only hire certified nurses aides.

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.

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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(3)	hrs	$	9,646	$ 694,546	$	9,646	$ 694,546	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,953	212,619		2,953	212,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,338	744,311		10,338	744,311	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				285,101		285,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)				15,684			15,684	12
13	Other (specify): Oxygen	39(2)					4,188		4,188	13
14	TOTAL			$	22,937	$ 1,667,160	$ 289,289	22,937	$ 1,956,449	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: **Countryside Care Centre**
IDPH License ID Number: **0051763**
Fiscal Year End: **12/31/2014**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

	Description	Units	Amount
5301	INHALATION THERAPY-PRIVATE		119
5303	INHALATION THERAPY-MEDICARE		874
5305	INHALATION THERAPY-MEDICAID		1,139
5308	INHALATION THERAPY-MANAGED CR		480
5753	OTHER SERVICES - MEDICARE		1,063
5755	OTHER SERVICES - MEDICAID		133
5853	I.V THERAPY- MEDICARE		1,911
5855	I.V. THERAPY-MEDICAID		3,146
15885	RESPIRATORY		5,893
15888	PROGRAM CONSULTANT		926
	Total - Line 12	**-**	**15,684**

STATE OF ILLINOIS

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 213,538	$ 213,538	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 420,874)	6,778,871	6,778,871	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,798	2,798	6
7	Other Prepaid Expenses	194,038	194,038	7
8	Accounts Receivable (owners or related parties)	20,636	20,636	8
9	Other(specify): See Schedule 17A	111	111	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,209,992	$ 7,209,992	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,007,975	1,007,975	15
16	Equipment, at Historical Cost	725,441	754,440	16
17	Accumulated Depreciation (book methods)	(321,296)	(320,133)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Lease Cost	23,239	23,239	22
23	Other(specify): See Schedule 17A	481,929	481,929	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,917,288	$ 1,947,450	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,127,280	$ 9,157,442	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,209,703	$ 1,209,703	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,255	148,255	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	164,200	164,200	32
33	Accrued Interest Payable	472	472	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,117,186	2,117,186	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,639,816	$ 3,639,816	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,495,421	2,495,421	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,495,421	$ 2,495,421	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,135,237	$ 6,135,237	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,992,043	$ 3,022,205	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,127,280	$ 9,157,442	48

***(See instructions.)**

Facility Name: **Countryside Care Centre**
IDPH License ID Number: **0051763**
Fiscal Year End: **12/31/2014**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
1128	EMPLOYEE LOANS/WAGE ASSIGNMTS	160	160
1134	INVENTORY-LINENS	(49)	(49)
	Total - Line 9	**111**	**111**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

	Description	Operating	After Consolidation
1125	SECURITY DEPOSIT	271,874	271,874
1126	REAL ESTATE ESCROW DEPOSIT	210,055	210,055
	Total - Line 23	**481,929**	**481,929**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
1204	EXCHANGE FORMATION L/H	490,081	490,081
1206	DUE TO DPA	617,257	617,257
1209	SECURITY DEPOSIT PAYABLE	67,301	67,301
1210	OPERATING EXPENSES	93,619	93,619
1212	MANAGEMENT FEES - SYMPHONY	196,333	196,333
1214	INSURANCE ALLOWANCE - WC/GLPL - DE	151,773	151,773
1220	STATE UNEMPLOYMENT TAX	(35,528)	(35,528)

1221	STATE UNEMPLOYMENT TAX	8,985	8,985
1222	FEDERAL UNEMPLOYMENT TAX	1,256	1,256
1223	SALES TAX	236	236
1224	PAYROLL TAXES OTHER	15,563	15,563
1226	ACCRUED EMPLOYEE BENEFITS	302,731	302,731
1232	FICA & W/H FED	48,664	48,664
1233	ILL W/H	8,814	8,814
1242	DUE TO IDPA-ADD'TL BED TAX	59,656	59,656
1252	DUE TO NUCARE	20,238	20,238
1253	DUE TO SYMPHONY	17,550	17,550
1258	PATIENT PERSONAL FUNDS	52,657	52,657
	Total - Line 36	**2,117,186**	**2,117,186**

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,656,177	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	(6,526)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,649,651	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,342,392	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)**	$ 1,342,392	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)**	$ 2,992,043	24	*

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

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,407,228	1
2	Discounts and Allowances for all Levels	(3,073,851)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,333,377	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,424,630	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,424,630	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	287,013	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,329	19
20	Radiology and X-Ray	8,994	20
21	Other Medical Services	31,464	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 376,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,733	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,733	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)**	$ 16,140,540	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,852,640	31
32	Health Care	4,935,571	32
33	General Administration	3,196,539	33
	B. Capital Expense		
34	Ownership	1,976,319	34
	C. Ancillary Expense		
35	Special Cost Centers	2,353,062	35
36	Provider Participation Fee	484,017	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,798,148	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,342,392	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,342,392	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,931,667	44
45	Private Pay - Net Inpatient Revenue	884,581	45
46	Medicare - Net Inpatient Revenue	3,414,048	46
47	Other-(specify) Hospice	1,035,186	47
48	Other-(specify) Managed Care	1,067,895	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,333,377	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

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

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

Tax return prepared on cash basis.

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2,039	2,291	$ 100,769	$ 43.98	1
2	Assistant Director of Nursing	5,987	6,405	156,437	24.42	2
3	Registered Nurses	30,729	32,953	1,095,034	33.23	3
4	Licensed Practical Nurses	25,557	28,226	730,199	25.87	4
5	CNAs & Orderlies	136,651	148,624	1,934,793	13.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,451	8,143	186,905	22.95	8
9	Activity Director	3,515	4,097	67,246	16.41	9
10	Activity Assistants	5,811	6,874	64,379	9.37	10
11	Social Service Workers	4,632	5,106	94,135	18.44	11
12	Dietician					12
13	Food Service Supervisor	3,905	4,150	83,998	20.24	13
14	Head Cook	6,511	7,686	82,670	10.76	14
15	Cook Helpers/Assistants	27,941	29,468	243,115	8.25	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,090	57,287	27.41	17
18	Housekeepers	18,904	20,390	257,052	12.61	18
19	Laundry	6,572	7,306	84,687	11.59	19
20	Administrator	1,988	2,138	121,660	56.90	20
21	Assistant Administrator	1,993	2,090	63,532	30.40	21
22	Other Administrative					22
23	Office Manager	4,749	5,187	106,048	20.45	23
24	Clerical	7,080	7,595	116,148	15.29	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	3,796	4,181	129,888	31.07	31
32	Other Health C: Ward Clerk	3,789	4,193	55,551	13.25	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	311,531	339,193	$ 5,831,533 *	$ 17.19	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,510	1(3)	35
36	Medical Director	Monthly	21,090	9(3)	36
37	Medical Records Consultant	Monthly	116	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,816	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,344	11(3)	44
45	Social Service Consultant	Monthly	284	12(3)	45
46	Other(specify) Wound Care Consult	Monthly	504	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 60,664		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Kohls	Administrator	0	$ 81,031
Daniela Clevenger	Administrator	0	40,629
Daniela Clevenger	Assistant Administrator	0	63,532
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 185,192

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in col. 7)	$ 724,333
TOTAL (agree to Schedule V, line 17, col. 3)	$ 724,333
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 311,521
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 311,521

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 146,410
Unemployment Compensation Insurance	83,632
FICA Taxes	434,717
Employee Health Insurance	377,035
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	13,810
Employee Benefits - Other	12,092
Employees' Physical Exams	11,247
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,078,943

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	651
Health Care Worker Background Check	7,650
(Indicate # of checks performed 638)	
Patient Background Checks 27	325
Miscellaneous Licenses & Fees	1,957
Illinois Council on Long Term Care	20,341
Miscellaneous Dues & Subscriptions	5,573
Lobbying Expense	(6,712)
Allocated from Mgmt. Co.	4,139
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,904

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,883
Allocated from Home Office	18,712
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,595

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Countryside Care Centre**
IDPH License ID Number: **0051763**
Fiscal Year End: **12/31/2014**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK	SECURE EXCHANGE	1,938
ACHIEVE ACCREDITATION	ACCREDITATION	9,904
ALLEN A LEFKOVITZ	LEGAL	16,312
ALLSCRIPTS	MANAGEMENT FACILITY SUBSCRIPTION	3,249
AON ESOLUTIONS	RISK CONSOLE	1,716
BOA - M. HARTMAN	WEB HOSTING	38
COMCAST	BUSINESS CLASS INTERNET	27,335
CREATIVE TECHNOLOGY	MONTHLY IT SUPPORT	14,901
DOCUMENTATION SOLUTIONS	CLAIMS REVIEW	1,215
EHEALTH DATA SOLUTIONS	RISK CONSOLE	5,112
HDSI	DATA PROCESSING	4,737
HIPP LAW OFFICE	COLLECTION	8,516
HK PAYROLL SERVICES	WORK TAX CREDIT	2,224
IMMIGRATION ATTOURNEYS	LEGAL	1,500
IT/SOURCETECH	OPERATOR MONTHLY SUPPORT	1,380
JEREMY PIERSON	WEBSITE WORK	115
LIFE SAFETY RESOURCES	FSES PREPARATION	3,395
MCGLADREY LLP	ACCOUNTING	28,317
MERCER	MEDICAL STOP LOSS PRICING	293
MUCH SHELIST	ANNUAL REPRESENTATION	1,363
PERSONNEL PLANNERS INC	UNEMPLOYMENT CLAIMS	3,388
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION	1,380
POINT B COMMUNICATIONS	WEB HOSTING	986
PROVINET SOLUTIONS	OUTSOURCED IT SERVICES	1,334
SPREADING THE WORD THRU	INTERPRETER SERVICES	80
STONE MCGUIRE & SIEGEL	LEGAL - COMPLIANCE	14,491

SYMPHONY FINANCIAL SERV	PROFESSIONAL FEES	101,004
TELEMEDICINE SOLUTIONS	WOUND ROUNDS CARE	16,149
THE JOINT COMMISSION	ACCREDITATION	2,950
TONIC HEALTHCAE RESOURC	NURSE CONSULTING	4,809
WESCOM SOLUTIONS INC	DATA PROCESSING	30,845
ZIR-MED	ELIGIBILITY VERIFICATION	547

Total (agree to Schedule V, line 19, column 3)	311,521

Allocated from Management Company Legal Fees	2,336
Allocated from Management Company Professional Services	30,044
Less: Non-Allowable Legal Fees	(16,312)
Less: Non-Allowable Legal Fees	(8,516)
Total (agree to Schedule V, line 19, column 8)	319,073

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Countryside Care Centre # 0051763 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $13,629**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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? **5 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **No** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **484,017**
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? **No** 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? **5**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.