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: 0050708

Facility Name: Countryside Nrsg & Rehab Ctr

Address: 1635 East 154th St (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: 12/16/09

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: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
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 01/01/14 to 12/31/14 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) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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 Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	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	28,035	641	4,944	33,620	8
9	SNF/PED					9
10	ICF	27,194			27,194	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,229	641	4,944	60,814	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.58%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 11/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/90 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 4,308

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	240,250	31,862	12,108	284,220		284,220	197	284,417			1
2	Food Purchase		339,168		339,168		339,168	(43)	339,125			2
3	Housekeeping	234,274	48,538		282,812		282,812	660	283,472			3
4	Laundry	30,438	17,764		48,202		48,202		48,202			4
5	Heat and Other Utilities			157,313	157,313		157,313	1,488	158,801			5
6	Maintenance	106,802		122,374	229,176		229,176	21,559	250,735			6
7	Other (specify):* See Supplemental	41,981		1,229	43,210		43,210	1,004	44,214			7
8	TOTAL General Services	653,745	437,332	293,024	1,384,101		1,384,101	24,865	1,408,966			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,039,848	98,274	16,876	2,154,998		2,154,998		2,154,998			10
10a	Therapy	116,988			116,988		116,988		116,988			10a
11	Activities	117,239	11,915	870	130,024		130,024		130,024			11
12	Social Services	303,321	18,853	1,560	323,734		323,734		323,734			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,577,396	129,042	31,306	2,737,744		2,737,744		2,737,744			16
	C. General Administration											
17	Administrative	254,188			254,188		254,188	26,151	280,339			17
18	Directors Fees											18
19	Professional Services			526,101	526,101	(56,167)	469,934	(285,884)	184,050			19
20	Dues, Fees, Subscriptions & Promotions			40,065	40,065		40,065	(12,729)	27,336			20
21	Clerical & General Office Expenses	264,788	20,213	985,075	1,270,076		1,270,076	(824,243)	445,833			21
22	Employee Benefits & Payroll Taxes			589,018	589,018		589,018	(1,623)	587,395			22
23	Inservice Training & Education			34	34		34		34			23
24	Travel and Seminar			4,151	4,151		4,151	340	4,491			24
25	Other Admin. Staff Transportation			15,970	15,970		15,970	1,667	17,637			25
26	Insurance-Prop.Liab.Malpractice			262,566	262,566		262,566	1,792	264,358			26
27	Other (specify):* See Supplemental							29,538	29,538			27
28	TOTAL General Administration	518,976	20,213	2,422,980	2,962,169	(56,167)	2,906,002	(1,064,991)	1,841,011			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,750,117	586,587	2,747,310	7,084,014	(56,167)	7,027,847	(1,040,126)	5,987,721			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.

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	41,981		1,229
Alloc. - Extended Care Consulting, LLC			1,004
Total	41,981	-	2,233
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Alloc. - Extended Care Consulting, LLC			29,538
Total	-	-	29,538

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Vendor	Amount	Allowable
Victoria Vasser	6,566	6,566
Care Consultants of Illinois	1,898	1,898
Taylor Lamont	4,250	4,250
Callie Graham	65	65
Rossley Bradley	528	528
Other	2,663	2,663
Alloc. - Extended Care Consulting, LLC	1,667	1,667
Total	17,637	17,637

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 3 Supplemental Schedule - Reclass

Description	Cost Center	Increase	Decrease
Real Estate Taxes	33	56,167	
Professional Fees	19		56,167

Facility Name & ID Number Countryside Nrsg & Rehab Ctr #0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			23,003	23,003		23,003	170,647	193,650			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,984	29,984		29,984	288,316	318,300			32
33	Real Estate Taxes			566,469	566,469	56,167	622,636	(48,359)	574,277			33
34	Rent-Facility & Grounds			781,704	781,704		781,704	(780,000)	1,704			34
35	Rent-Equipment & Vehicles			22,560	22,560		22,560	980	23,540			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,423,720	1,423,720	56,167	1,479,887	(368,416)	1,111,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		217,228	528,411	745,639		745,639	(1,021)	744,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			451,027	451,027		451,027		451,027			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		217,228	979,438	1,196,666		1,196,666	(1,021)	1,195,645			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,750,117	803,815	5,150,468	9,704,400		9,704,400	(1,409,563)	8,294,837			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

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Total	-	-	-

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				9
10	Interest and Other Investment Income	(11,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(925)	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	(7,366)	21		18
19	Entertainment				19
20	Contributions	(875)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(913,200)	21		24
25	Fund Raising, Advertising and Promotional	(14,022)	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 See Supplemental	(173,271)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,120,663)		$	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)	(288,900)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (288,900)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,409,563)		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 Nrsg & Rehab Ctr

ID# 0050708

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (374)	21	1
2	Collections	(3,322)	19	2
3	Bank Charges	(23,323)	21	3
4	Settlement	(24,318)	21	4
5	Legal	(53,022)	19	5
6	Capitalized Assets < $2,500	4,564	06	6
7	Other Professional	(8,459)	19	7
8	RE Tax Refund - 2011	(51,578)	33	8
9				9
10				10
11				11
12				12
13				13
14	Countryside Healthcare Center, LLC			14
15	Professional Fees	(2,463)	19	15
16	Administration	(61)	21	16
17	Amortization	(10,915)	31	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**	(173,271)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	197	0	0	0	0	0	0	0	0	197	1
2	Food Purchase	(925)	0	882	0	0	0	0	0	0	0	0	(43)	2
3	Housekeeping	0	0	660	0	0	0	0	0	0	0	0	660	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,488	0	0	0	0	0	0	0	0	1,488	5
6	Maintenance	4,564	0	6,142	10,853	0	0	0	0	0	0	0	21,559	6
7	Other (specify):*	0	0	0	1,004	0	0	0	0	0	0	0	1,004	7
8	**TOTAL General Services**	3,639	0	9,369	11,857	0	0	0	0	0	0	0	24,865	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	4,082	22,069	0	0	0	0	0	0	0	26,151	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(67,266)	2,463	(221,081)	0	0	0	0	0	0	0	0	(285,884)	19
20	Fees, Subscriptions & Promotions	(14,897)	0	2,168	0	0	0	0	0	0	0	0	(12,729)	20
21	Clerical & General Office Expenses	(968,642)	61	14,848	129,490	0	0	0	0	0	0	0	(824,243)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(1,623)	0	0	0	0	0	0	0	(1,623)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	340	0	0	0	0	0	0	0	0	340	24
25	Other Admin. Staff Transportation	0	0	1,667	0	0	0	0	0	0	0	0	1,667	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,792	0	0	0	0	0	0	0	0	1,792	26
27	Other (specify):*	0	0	0	29,538	0	0	0	0	0	0	0	29,538	27
28	**TOTAL General Administration**	(1,050,805)	2,524	(196,184)	179,474	0	0	0	0	0	0	0	(1,064,991)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,047,166)	2,524	(186,815)	191,331	0	0	0	0	0	0	0	(1,040,126)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	0	165,125	5,522	0	0	0	0	0	0	0	0	170,647	30
31	Amortization of Pre-Op. & Org.	(10,915)	10,915	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,004)	298,056	1,264	0	0	0	0	0	0	0	0	288,316	32
33	Real Estate Taxes	(51,578)	0	3,219	0	0	0	0	0	0	0	0	(48,359)	33
34	Rent-Facility & Grounds	0	(780,000)	0	0	0	0	0	0	0	0	0	(780,000)	34
35	Rent-Equipment & Vehicles	0	0	980	0	0	0	0	0	0	0	0	980	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(73,497)	(305,904)	10,985	0	0	0	0	0	0	0	0	(368,416)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	(1,021)	0	0	0	0	(1,021)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	(1,021)	0	0	0	0	(1,021)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,120,663)	(303,380)	(175,830)	191,331	0	0	(1,021)	0	0	0	0	(1,409,563)	45

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Supp		See Page 6 - Supp		See Page 6 - Supp		

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	34	Rent	$ 780,000	Countryside Healthcare Center, LLC	100.00%	$	$ (780,000)	1
2	V	32	Interest		Countryside Healthcare Center, LLC	100.00%			2
3	V	19	Professional Fees		Countryside Healthcare Center, LLC	100.00%	2,463	2,463	3
4	V	21	Office		Countryside Healthcare Center, LLC	100.00%	61	61	4
5	V	26	Property Insurance		Countryside Healthcare Center, LLC	100.00%			5
6	V	30	Depreciation		Countryside Healthcare Center, LLC	100.00%	165,125	165,125	6
7	V	31	Amortization		Countryside Healthcare Center, LLC	100.00%	10,915	10,915	7
8	V	32	Interest		Countryside Healthcare Center, LLC	100.00%	298,056	298,056	8
9	V	33	Real Estate Taxes	566,469	Countryside Healthcare Center, LLC	100.00%	566,469		9
10	V	36	Mortgage Insurance Premiums		Countryside Healthcare Center, LLC	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,346,469			$ 1,043,089	$ * (303,380)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Eric Rothner	2.00%	Avenue Care Nursing and Rehab	Chicago, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Rothner Family Grandchildren Trust	10.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	N & S Rothner Family Trust	88.00%	Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			South Suburban Rehabilitation Center	Chicago, IL	Countryside			11
12			Tri-State Nursing and Rehab	Lansing, IL	Healthcare Ctr	Dolton, IL	Bldg. Company	12
13			Wheaton Care Center	Wheaton, IL				13
14			Kensington Place Nursing and Rehab	Chicago, IL				14
15			Countryside Nursing and Rehab	Dolton, IL				15
16			Spring Creek Nursing and Rehab	Joliet, IL				16
17			Park House Nursing and Rehab	Chicago, IL				17
18			Timber Point Healthcare Center	Camp Point, IL				18
19			Prairie Village Healthcare Center	Jacksonville, IL				19
20			Major Hospital - Dyer	Dyer, IN				20
21			Major Hospital - Lake County	East Chicago, IN				21
22			Major Hospital - Sebo	Holbart, IN				22
23			Major Hospital - Lincolnshire	Merrillville, IN				23
24			Major Hospital - Munster	Munster, IN				24
25			McKinley Health Care Center	Canton, OH				25
26			St. James Manor	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$	Extended Care Consulting, LLC	100.00%	$ 197	$ 197	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	882	882	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	660	660	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	1,488	1,488	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	6,142	6,142	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,082	4,082	20
21	V	19	Professional Fees	232,721	Extended Care Consulting, LLC	100.00%	11,640	(221,081)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,168	2,168	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	14,848	14,848	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	340	340	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,667	1,667	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,792	1,792	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	5,522	5,522	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,264	1,264	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,219	3,219	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	980	980	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			$ 232,721			$ 56,891	$ * (175,830)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	6	Maintenance (Pooled)	$	Extended Care Consulting, LLC	100.00%	$ 10,853	$ 10,853	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,004	1,004	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	22,069	22,069	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	129,490	129,490	20
21	V	21	Office and Clerical (Direct)	17,007	Extended Care Consulting, LLC	100.00%	17,007		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,915	27,915	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,623	1,623	23
24	V	22	Employee Benefits	1,623				(1,623)	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			$ 18,630			$ 209,961	$ * 191,331	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,727	Care Centers Health Systems, Inc.	100.00%	$ 1,727	$	15
16	V	10	Nursing	34	Care Centers Health Systems, Inc.	100.00%	34		16
17	V	39	Ancillary	1,184	Care Centers Health Systems, Inc.	100.00%	1,184		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			$ 2,945			$ 2,945	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Ancillary	$	Tricare Rehab	100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary	3,625	Reliable Medical of the Midwest, LLC	100.00%	2,604	(1,021)	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			$ 3,625			$ 2,604	$ * (1,021)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Benefits	$ 92,510	CCS VEBA	100.00%	$ 92,510	$	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			$ 92,510			$ 92,510	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Ancillary	$	Vent Lease, LLC	100.00%	$	$	15
16	V	32	Interest		Vent Lease, LLC	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC	100.00%			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Adam Vales	Relative	Clerical	0.00%	See Attached	0.79	1.98%	Salary	$ 2,312	22 - 7	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	$ 2,312		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	Patient Days	1,251,572	31	$ 4,057	$	60,814	$ 197	1
2	2	Food	Patient Days	1,251,572	31	18,150		60,814	882	2
3	3	Housekeeping	Patient Days	1,251,572	31	13,578		60,814	660	3
4	5	Utilities	Patient Days	1,251,572	31	30,626		60,814	1,488	4
5	6	Maintenance	Patient Days	1,251,572	31	126,400		60,814	6,142	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		60,814	4,082	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		60,814	11,640	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		60,814	2,168	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		60,814	14,848	9
10	24	Travel and Seminar	Patient Days	1,251,572	31	6,989		60,814	340	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		60,814	1,667	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		60,814	1,792	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		60,814	5,522	13
14	32	Interest	Patient Days	1,251,572	31	26,010		60,814	1,264	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		60,814	3,219	15
16	35	Rent - Equipment and Auto	Patient Days	1,251,572	31	20,168		60,814	980	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 56,891	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	6	Maintenance	Patient Days	1,251,572	31	$ 217,811	$ 217,811	60,814	$ 10,583	1
2	6	Maintenance	Direct	1	1			1		2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,251,572	31	20,665		60,814	1,004	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,251,572	31	454,189	454,189	60,814	22,069	5
6	21	Office and Clerical	Patient Days	1,251,572	31	2,664,950	2,664,951	60,814	129,490	6
7	21	Office and Clerical	Direct	1	1	17,007	17,007	1	17,007	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,251,572	31	574,509	574,509	60,814	27,915	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	1,623		1	1,623	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					$ 3,950,754	$ 3,928,467		$ 209,691	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Avenue #246
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612 - 5662
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	Dietary	Profit Margin %	77,896	21	$ 77,896	$	1,727	$ 1,727	1
2	10	Nursing	Profit Margin %	234	21	234		34	34	2
3	39	Ancillary	Profit Margin %	97,004	21	97,004		1,184	1,184	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					$ 175,134	$		$ 2,945	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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, Illinois 60162
Phone Number: (708) 449 - 9400
Fax Number: (708) 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	Ancillary	Profit Margin %	9,580,898	12	$ 8,898,201	$		$	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					$ 8,898,201	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue, Suite 246
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (847) 566 - 0800
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	Dietary	Profit Margin %	70	12	$ 50	$		$	1
2	10	Nursing	Profit Margin %	32,887	12	23,627				2
3	39	Ancillary	Profit Margin %	85,782	12	61,627		3,625	2,604	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					$ 85,304	$		$ 2,604	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 VEBA
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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 Benefits	Direct Allocations	1	1	$ 92,510	$	1	$ 92,510	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					$ 92,510	$		$ 92,510	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: Vent Lease, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905 - 3000
Fax Number: (847) 491 - 9565

	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	Ancillary	Profit Margin %	110,244	18	$ 110,244	$		$	1
2	32	Depreciation	Direct	2,695	1	2,695				2
3	30	Interest	Direct	2,944	1	2,944				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					$ 115,883	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Inland Bank		X	Mortgage			$ 7,100,000	$ 6,752,722			$ 298,056	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							29,984	6
7	Alloc. - Extended Care Con.	X		Line of Credit							1,264	7
8												8
9	TOTAL Facility Related						$ 7,100,000	$ 6,752,722			$ 329,304	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(11,004)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,004)	14
15	TOTALS (line 9+line14)						$ 7,100,000	$ 6,752,722			$ 318,300	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # 36

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

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 Nrsg & Rehab Ctr # 0050708 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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.**	$ 589,680	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.)		$ 567,194	2
3. Under or (over) accrual (line 2 minus line 1).		$ (22,486)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 592,174	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.)**		$ 56,167	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 $ 51,578 For 2011 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (51,578)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 574,277	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	439,138	8
	2010	449,999	9
	2011	757,033	10
	2012	561,600	11
	2013	563,975	12

2014 Real Estate Tax Accrual = $563,975 * 1.05 = $592,174

Extended Care Consulting, LLC (Allocations) = $3,219

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Nrsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050708

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) - 327 - 8417

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.	29-13-100-001-0000	Long Term Care Facility	$ 563,975.42	$ 563,975.42
2.	Alloc. - Ext. Care Consulting	Long Term Care Facility	$ 162,082.08	$ 3,065.38
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 726,057.50	$ 567,040.80

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 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.

Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/14 - 12/31/14

Page 10 Supplemental Schedule

Vendor	Description		Amount
Appeal Costs			
Finkel, Martwick & Colson, P.C.	2010 - Tax Refund / Reduction		2,052
Finkel, Martwick & Colson, P.C.	2011 - Tax Refund / Reduction		13,070
Finkel, Martwick & Colson, P.C.	2012 - Tax Refund / Reduction		35,046
First Real Estate			6,000
Total - Line 5 Total			56,167
Refunds			
	2011 - Tax Refund		51,578
Total			51,578
Refund Adjustment			
Appeal Costs			56,167
Real Estate Tax Refund		51,578	
Appeal Costs		56,167	
Remainder		(4,589)	
1/2 of Remainder			(4,589)
Total - Line 6 Total			51,578

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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).

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			$ 392,750	1
2	Alloc. - Ext. Care			15,508	2
3	TOTALS			$ 408,258	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Various			1991	24,648						9
10	Various			1992	28,172						10
11	Various			1993	11,940						11
12	Various			1994	4,878						12
13	Various			1995	34,004						13
14	Various			1996	20,232						14
15	Various			1997	17,236						15
16	Various			1998	13,979						16
17	Various			1999	33,838						17
18	Various			2000	18,955						18
19	Various			2001	8,806						19
20	Various			2003	136,685						20
21	Various			2004	49,614						21
22	Various			2005	80,983						22
23	Various			2006	65,138						23
24	Various			2007	46,168						24
25	Various			2008	74,086						25
26	Various			2010	8,569	593		593		4,266	26
27	Compressor			2011	2,760	552		552		1,748	27
28	Bathroom / Shower (Tile, Drywall, Piping)			2011	6,197	310		310		930	28
29	Kitchen Countertop			2011	3,200	160		160		480	29
30	Rehab Renovations (Tile Work)			2011	6,517	326		326		978	30
31	Sunroom Rehab (tile, Drywall, Studs, Paint, Electrical Switch)			2011	2,983	149		149		447	31
32	D Wing - Base, Drywall, Tape, Paint, Tile and Adhesive			2012	6,779	339		339		847	32
33	SS Office - Base, Drywall, Tape, Paint, and Locks			2012	1,622	81		81		203	33
34	Reception Area - Tile and Adhesive			2012	2,763	138		138		345	34
35	Hallways - Tile and Adhesive, Concrete			2012	13,924	696		696		1,741	35
36	B Wing - Tile and Adhesive, Base, Drywall, Handrail, and Paint			2012	21,761	1,088		1,088		2,720	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Smokehouse - Storage Unit, Electric, Door, and Locks	2012	$ 18,862	$ 943		$ 943	$	$ 2,122	37
38	Dining Room - Electrical and Paint	2012	2,683	134		134		302	38
39	Kitchen - Paint	2012	2,219	111		111		250	39
40	Hot Water Tank	2012	3,290						40
41	Concrete - Outside Back of Building	2013	4,350	218		218		344	41
42	Flooring - Dining Room	2013	14,944	747		747		1,059	42
43	Roof	2013	84,500	4,225		4,225		4,929	43
44	Heat Exchanger - Roof	2013	4,959	992		992		1,322	44
45	Doors - Delayed Egress Mag Lock	2014	3,573	90		90		90	45
46	Sprinkler System	2014	11,500	96		96		96	46
47	Drywall - Wings	2014	18,000	150		150		150	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Countryside Healthcare Center, LLC								55
56									56
57	Building	1977	5,408,525	156,005		156,005		3,711,774	57
58	Various	2001	256,048	9,120		9,120		130,392	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)		$ 6,579,890	$ 177,263		$ 177,263	$	$ 3,867,535	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 Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12A, Carried Forward		$ 6,579,890	$ 177,263		$ 177,263	$	$ 3,867,535	1
2	Related Party Allocations - See Supplemental Schedules								2
3									3
4	Allocations - Extended Care Consulting, LLC	2007	224	11		11		89	4
5	Allocations - Extended Care Consulting, LLC	2009	134	7		7		40	5
6	Allocations - Extended Care Consulting, LLC	2010	1,311	65		65		328	6
7	Allocations - Extended Care Consulting, LLC	2011	472	24		24		94	7
8	Allocations - Extended Care Consulting, LLC	2013	155	8		8		23	8
9	Allocations - Extended Care Consulting, LLC	2014	2,155	108		108		108	9
10									10
11									11
12	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	21,371	548		548		6,735	12
13	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	17,654	1,505		1,505		17,654	13
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	20,805	1,773		1,773		20,805	14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	1,034	110		110		922	15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	187	9		9		56	16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	2,979	149		149		149	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)		$ 6,648,371	$ 181,580		$ 181,580	$	$ 3,914,538	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 Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 39,047	$ 9,858	$ 9,858	$	5 - 7	$ 27,557	71
72	Current Year Purchases	37,175	1,007	1,007		5	1,007	72
73	Fully Depreciated Assets							73
74	See Supplemental	547,221	957	957			541,121	74
75	TOTALS	$ 623,443	$ 11,822	$ 11,822	$		$ 569,685	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	Alloc. - Ext. Care Consult.			$ 8,769	$ 248	$ 248	$		$ 7,778	76
77										77
78										78
79										79
80	TOTALS			$ 8,769	$ 248	$ 248	$		$ 7,778	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)	$ 7,688,841	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,650	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,650	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,492,001	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Countryside Nursing & Rehab Center, LLC
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Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Related Party 1 - Countryside Healthcare Center, LLC			
Prior	394,000		394,000
Current			
Total	394,000	-	394,000
Related Party 2 - Extended Care Consulting, LLC			
Prior	143,709	598	140,844
Current	3,594	359	359
Total	147,303	957	141,203
Related Party 3 - Extended Care Consulting, LLC / 2201 Main, LLC			
Prior	5,918		5,918
Current			
Total	5,918	-	5,918
Related Party 4 - Extended Care Clinical, LLC / 2201 Main, LLC			
Prior			
Current			
Total	-	-	-
Total	**547,221**	**957**	**541,121**

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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:				$			3
4	Additions							4
5	See							5
6	Supplement				1,704			6
7	TOTAL				$ 1,704 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 18,101 Description: See Supplemental 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	Infinity	$	$ 5,439	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,439	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

Countryside Nursing & Rehab Center, LLC
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Mobile Mini, Inc.	1,704
Total	1,704

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Aqua Coolers	816
Hughes Enterprises, Inc.	12,144
Neopost USA, Inc.	31
US Gas	66
Xerox Financial Services	4,064
Alloc. - Extended Care Consulting, LLC	980
Total	18,101

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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	$		$ 213,684	$		$ 213,684	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			50,238			50,238	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			238,359			238,359	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				205,893		205,893	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					11,335		11,335	12
13	Other (specify): See Supplemental	39 - 03				26,130			26,130	13
14	TOTAL			$		$ 528,411	$ 217,228		$ 745,639	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

Countryside Nrsg & Rehab Ctr
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Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	637	
Oxygen	6,032	
Feed Tube Supplements	345	
Therapy and Rehab Supplies	4,321	
Low Pressure Mattress		5,109
Food Pump		1,739
Laboratory		8,868
Radiology		5,378
Other		5,036
Total	11,335	26,130

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$	$ 353,055	1
2	Cash-Patient Deposits	52,104	52,104	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 749,805)	1,939,984	1,939,984	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	338,621	338,621	6
7	Other Prepaid Expenses	54,809	54,809	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	5,000	5,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,390,518	$ 2,743,573	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		5,408,525	14
15	Leasehold Improvements, at Historical Cost	239,565	494,790	15
16	Equipment, at Historical Cost	93,890	487,890	16
17	Accumulated Depreciation (book methods)	(53,933)	(4,290,099)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	1,876,427	4,443,211	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,155,949	$ 6,937,067	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,546,467	$ 9,680,640	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,032,299	$ 2,032,299	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,915	65,915	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,351	255,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,291	8,291	31
32	Accrued Real Estate Taxes(Sch.IX-B)		592,174	32
33	Accrued Interest Payable		8,872	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,361,856	$ 2,962,902	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,752,722	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,752,722	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,361,856	$ 9,715,624	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,184,611	$ (34,984)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,546,467	$ 9,680,640	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Countryside Nrsg & Rehab Ctr
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Due from Others	5,000	5,000
Total	5,000	5,000
Line 23 - Other Long Term Assets		
Due from Related Parties	1,876,427	4,400,460
Financing Costs (Net of Amortization)		42,751
Total	1,876,427	4,443,211
Line 36 - Other Current Liabilities		
Total	-	-
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,483,842	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,483,842	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	200,769	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	(500,000)	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)**	$ (299,231)	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)**	$ 2,184,611	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 9,825,248	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,825,248	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,543	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 68,543	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,004	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,004	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	374	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 374	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,905,169	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,384,101	31
32	Health Care	2,737,744	32
33	General Administration	2,962,169	33
	B. Capital Expense		
34	Ownership	1,423,720	34
	C. Ancillary Expense		
35	Special Cost Centers	745,639	35
36	Provider Participation Fee	451,027	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,704,400	40
41	**Income before Income Taxes (line 30 minus line 40)****	200,769	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 200,769	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,375,514	44
45	Private Pay - Net Inpatient Revenue	86,535	45
46	Medicare - Net Inpatient Revenue	2,069,881	46
47	Other-(specify) Hospice - Net Inpatient Revenue	137	47
48	Other-(specify) Insurance - Net Inpatient Revenue	293,181	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,825,248	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryside Nrsg & Rehab Ctr
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Other Income	374	374
Total	374	374

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,973	2,043	$ 93,145	$ 45.59	1
2	Assistant Director of Nursing	1,591	1,692	61,466	36.33	2
3	Registered Nurses	17,082	18,903	567,474	30.02	3
4	Licensed Practical Nurses	26,240	28,345	649,539	22.92	4
5	CNAs & Orderlies	59,082	65,270	645,131	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,913	6,697	116,988	17.47	8
9	Activity Director	1,917	2,058	31,695	15.40	9
10	Activity Assistants	7,910	8,989	85,544	9.52	10
11	Social Service Workers	16,596	17,740	303,321	17.10	11
12	Dietician					12
13	Food Service Supervisor	1,845	2,126	39,821	18.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,217	19,418	200,429	10.32	15
16	Dishwashers					16
17	Maintenance Workers	5,699	6,386	106,802	16.72	17
18	Housekeepers	22,017	24,259	234,274	9.66	18
19	Laundry	2,784	3,076	30,438	9.90	19
20	Administrator	1,823	2,062	117,509	56.99	20
21	Assistant Administrator	3,686	4,048	79,324	19.60	21
22	Other Administrative	790	795	57,355	72.14	22
23	Office Manager					23
24	Clerical	11,092	12,543	264,788	21.11	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	1,911	2,094	23,093	11.03	31
32	Other Health Care(specify)					32
33	Other(specify) Security	3,690	4,035	41,981	10.40	33
34	TOTAL (lines 1 - 33)	210,858	232,579	$ 3,750,117 *	$ 16.12	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		$ 12,108	01 - 03	35
36	Medical Director		12,000	09 - 03	36
37	Medical Records Consultant		1,160	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		15,716	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		870	11 - 03	44
45	Social Service Consultant		1,560	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 43,414		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

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Callie Graham	Administrator	0	$ 117,509
Angela Noland	Asst. Admin.	0	79,324
Sherwin Ray	Administration	0	57,355
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 254,188

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
Extended Care Consulting, LLC	Home Office	$ 232,721
Personnel Planners, Inc.	Unemployment Consultant	3,213
Plante & Moran, PLLC	Accounting	19,500
Krupnick, Bokor & Kagda	Accounting	3,825
Frost, Ruttenber & Rothblatt, PC	Accounting	250
Paycor Payroll Services	Data Processing / IT	20,413
Medifax / EDI	Data Processing / IT	860
E-Health Data Solutions	Data Processing / IT	8,873
American Data	Data Processing / IT	5,069
MDI / Achieve	Data Processing / IT	4,351
Matrix Care	Data Processing / IT	28,386
See Supplemental Schedule		198,640
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 526,101

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,976
Unemployment Compensation Insurance	65,857
FICA Taxes	282,921
Employee Health Insurance	138,238
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	826
Holiday Expense	2,200
Other Employee Welfare	7,377
TOTAL (agree to Schedule V, line 22, col.8)	$ 587,395

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	$
Advertising: Employee Recruitment	17,577
Health Care Worker Background Check	3,825
(Indicate # of checks performed)	
Patient Background Checks	
Advertising and Public Relations	14,897
Dues and Subscriptions	928
Licenses	2,838
Alloc. - Extended Care Consulting	2,168
Less: Public Relations Expense	( )
Non-allowable advertising	(14,897)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,336

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,151
Alloc. - Extended Care Consulting	340
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,491

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryside Nursing & Rehab Center, LLC
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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Care Consultants of Illinois	Data Processing / IT	2,324
Singer Networks	Data Processing / IT	2,445
Care Management Facility	Data Processing / IT	2,971
Nebo Systems	Data Processing / IT	104
National Datacare Corporation	Data Processing / IT	2,701
Ability Network	Data Processing / IT	2,752
Coburn Enterprises	Data Processing / IT	12
Smart Technology Services	Data Processing / IT	3,630
Limitless Technology	Data Processing / IT	257
Other	Data Processing / IT	5,402
Wiliams, Montgomery & John, Ltd.	Legal	3,101
Holly Turner	Legal	1,489
Roff Goffman Martin	Legal	3
Chuhak & Tecscon	Legal	921
Ashman & Stein	Legal	8,039
Foley & Lardner	Legal	1,602
Hall Prangle	Legal	7,044
Hamlin Burton	Legal	6,978
McVey & Parsky, LLC	Legal	32
Finkel, Martwick & Colson, P.C.	Legal	80,161
Federal Insurance	Legal	222
Jean A. Adams Attorney at Law	Legal	788
O'Hagan	Legal	(17,031)
Western Litigation	Legal	35,000
Grabowski Law Services, LLC	Legal / Collections	3,322
HFG	Other	8,459
First Real Estate	Appraisal	6,000
Appraisal Research Counselors	Appraisal	(4,200)
Prospect Resources	Other	750
Terrill Consulting Services	Other	9,588
Resource Utilization Xperts	Other	11,984
Other	Other	11,790
Total		198,640

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Non-Allowable Amount
Finkel, Martwick & Colson, P.C.	12/05/13	2012 RE Tax Assessment		29,994
Hall Prangle	12/30/13	Non-Allowable		1,703
Grabowksi Law Center, LLC	01/02/14	Non-Allowable		344
Wiliams, Montgomery & John, Ltd.	01/20/14	Non-Allowable		143
Ashman & Stein	01/23/14	Non-Allowable		260
Ashman & Stein	02/19/14	Non-Allowable		983
Jean A. Adams Attorney at Law	02/24/14	Estate of EW	788	
McVey & Parsky, LLC	02/25/14	Non-Allowable		32
Ashman & Stein	03/12/14	Non-Allowable		33
Wiliams, Montgomery & John, Ltd.	03/26/14	Non-Allowable		41
Grabowksi Law Center, LLC	04/03/14	Non-Allowable		307
Ashman & Stein	04/11/14	Non-Allowable		1,289
Wiliams, Montgomery & John, Ltd.	04/18/14	Non-Allowable		94
Wiliams, Montgomery & John, Ltd.	05/15/14	Non-Allowable		33
Ashman & Stein	06/10/14	Non-Allowable		1,775
Hall Prangle	06/26/14	Lawsuit - SA	5,341	
Hamlin & Burton	06/27/14	Non-Allowable		6,978
O'Hagan	06/27/14	Non-Allowable		(699)
O'Hagan	06/27/14	Non-Allowable		(422)
O'Hagan	06/27/14	Non-Allowable		(1,594)
Ashman & Stein	07/31/14	Non-Allowable		1,109
HFG	07/31/14	Non-Allowable		188
Wiliams, Montgomery & John, Ltd.	07/31/14	Non-Allowable		8
Western Litigation	08/07/14	Non-Allowable		35,000
Ashman & Stein	08/27/14	Non-Allowable		1,013
Chuhak & Tecson	08/31/14	Non-Allowable		247
Wiliams, Montgomery & John, Ltd.	08/31/14	Non-Allowable		947
Holly Turner	09/09/14	Corporate Matters	250	
Roff Goffman Martin	09/26/14	Non-Allowable		3
Holly Turner	09/30/14	Corporate Matters	250	
Holly Turner	10/01/14	Corporate Matters	439	
Wiliams, Montgomery & John, Ltd.	10/15/14	Non-Allowable		526
Federal Insurance	10/19/14	Corporate Matters - AB	222	
Chuhak & Tecson	10/31/14	Non-Allowable		492
Chuhak & Tecson	10/31/14	Non-Allowable		182
Foley & Lardner, LLP	11/07/14	Corporate Matters - Review Cost Reports	193	
Ashman & Stein	11/30/14	Non-Allowable		1,577
Foley & Lardner, LLP	12/11/14	Corporate Matters - Review Cost Reports	1,410	
Wiliams, Montgomery & John, Ltd.	12/24/14	Non-Allowable		1,014
Wiliams, Montgomery & John, Ltd.	12/24/14	Non-Allowable		70
Finkel, Martwick & Colson, P.C.	12/31/14	2012 RE Tax Assessment	35,046	
Finkel, Martwick & Colson, P.C.	12/31/14	2012 RE Tax Assessment	15,121	
O'Hagan	12/31/14	Non-Allowable		(14,316)
Wiliams, Montgomery & John, Ltd.	01/14/15	Non-Allowable		226
Total			59,059	53,673

Page 21 Supplemental Schedule - Seminar Schedule

Name of Session	Sponsor	Attendee	Location	Seminar	Travel
Sub-Total				-	-
Non-Allowable				-	-
Total				-	-

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/14 Ending: 12/31/14

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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10 - 02**

(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. $ **451,027**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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? **100 Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees