FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 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 01/01/15 to 12/31/15 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: 01/01/15 Ending: 12/31/15

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	27,667	27	4,083	31,777	8
9	SNF/PED					9
10	ICF	26,837	27		26,864	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,504	54	4,083	58,641	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.55%

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 3,866

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

* 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: 01/01/15 Ending: 12/31/15

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	240,990	29,456	11,413	281,859		281,859	194	282,053			1
2	Food Purchase		343,768		343,768		343,768	(977)	342,791			2
3	Housekeeping	229,658	54,479		284,137		284,137	1,363	285,500			3
4	Laundry	46,129	14,484		60,613		60,613		60,613			4
5	Heat and Other Utilities			136,270	136,270		136,270	2,066	138,336			5
6	Maintenance	99,390		125,461	224,851		224,851	19,241	244,092			6
7	Other (specify):* See Supplemental	40,292		574	40,866		40,866	1,020	41,886			7
8	TOTAL General Services	656,459	442,187	273,718	1,372,364		1,372,364	22,907	1,395,271			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,085,554	108,265	43,268	2,237,087		2,237,087		2,237,087			10
10a	Therapy	107,407		320	107,727		107,727		107,727			10a
11	Activities	116,427	24,430	848	141,705		141,705		141,705			11
12	Social Services	286,221	15,481	824	302,526		302,526		302,526			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,595,609	148,176	57,260	2,801,045		2,801,045		2,801,045			16
	C. General Administration											
17	Administrative	299,380			299,380		299,380	24,498	323,878			17
18	Directors Fees											18
19	Professional Services			432,890	432,890	(34,409)	398,481	(262,329)	136,152			19
20	Dues, Fees, Subscriptions & Promotions			57,909	57,909		57,909	(20,813)	37,096			20
21	Clerical & General Office Expenses	239,830	1,964	1,117,122	1,358,916		1,358,916	(921,940)	436,976			21
22	Employee Benefits & Payroll Taxes			569,395	569,395		569,395	(4,272)	565,123			22
23	Inservice Training & Education			4,306	4,306		4,306		4,306			23
24	Travel and Seminar			4,114	4,114		4,114	418	4,532			24
25	Other Admin. Staff Transportation			17,403	17,403		17,403	(13,789)	3,614			25
26	Insurance-Prop.Liab.Malpractice			269,019	269,019		269,019	1,699	270,718			26
27	Other (specify):* See Supplemental							26,585	26,585			27
28	TOTAL General Administration	539,210	1,964	2,472,158	3,013,332	(34,409)	2,978,923	(1,169,943)	1,808,980			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,791,278	592,327	2,803,136	7,186,741	(34,409)	7,152,332	(1,147,036)	6,005,296			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
01/01/15 - 12/31/15

Reclassification

Description	Increase	Decrease
Line 19 Professional Fees		34,409
Line 33 Real Estate Taxes	34,409	

To reclassify legal fees incurred related to real estate assessment valuation for 2014.

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Security	40,292		574
Allocated - Extended Care Consulting			
Employee Benefits			1,020
Total	40,292	-	1,594
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Allocated - Extended Care Consulting			
Employee Benefits			26,585
Total	-	-	26,585

Facility Name & ID Number Countryside Nrsg & Rehab Ctr #0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			40,165	40,165		40,165	167,864	208,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,085	27,085		27,085	291,980	319,065			32
33	Real Estate Taxes			677,750	677,750	34,409	712,159	5,429	717,588			33
34	Rent-Facility & Grounds			781,731	781,731		781,731	(780,000)	1,731			34
35	Rent-Equipment & Vehicles			20,521	20,521		20,521	994	21,515			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,547,252	1,547,252	34,409	1,581,661	(313,733)	1,267,928			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		139,216	601,411	740,627		740,627		740,627			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			439,776	439,776		439,776		439,776			42
43	Other (specify):* See Supplemental	27,607			27,607		27,607	(27,607)				43
44	TOTAL Special Cost Centers	27,607	139,216	1,041,187	1,208,010		1,208,010	(27,607)	1,180,403			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,818,885	731,543	5,391,575	9,942,003		9,942,003	(1,488,376)	8,453,627			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
01/01/15 - 12/31/15

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Marketing	27,607		
Total	27,607	-	-

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(1,673)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,494)	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				18
19	Entertainment				19
20	Contributions		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	(947,690)	21		24
25	Fund Raising, Advertising and Promotional	(22,031)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(294,012)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,266,900)		$	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)	(221,476)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (221,476)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,488,376)		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: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Professional Fees - Collections	$ (3,596)	19	1
2	Professional Fees - Legal	(20,034)	19	2
3	Professional Fees - Other	(94,064)	19	3
4	Bank Charges	(12,425)	21	4
5	Settlement	(101,478)	21	5
6	Theft Loss	(32)	21	6
7	Other Admin Travel	(15,455)	25	7
8	Marketing	(27,607)	43	8
9	Fixed Assets Capitalized < $2,500	1,444	06	9
10				10
11				11
12				12
13				13
14				14
15				15
16	Countryside Healthcare Center, LLC			16
17	Management Fees	(9,850)	17	17
18	Amortization	(10,915)	31	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**	(294,012)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	194	0	0	0	0	0	0	0	0	194	1
2	Food Purchase	(1,494)	0	517	0	0	0	0	0	0	0	0	(977)	2
3	Housekeeping	0	0	1,363	0	0	0	0	0	0	0	0	1,363	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,066	0	0	0	0	0	0	0	0	2,066	5
6	Maintenance	1,444	0	5,945	11,852	0	0	0	0	0	0	0	19,241	6
7	Other (specify):*	0	0	0	1,020	0	0	0	0	0	0	0	1,020	7
8	**TOTAL General Services**	(50)	0	10,085	12,872	0	0	0	0	0	0	0	22,907	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	(9,850)	9,850	3,714	20,784	0	0	0	0	0	0	0	24,498	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(117,694)	0	(144,635)	0	0	0	0	0	0	0	0	(262,329)	19
20	Fees, Subscriptions & Promotions	(22,031)	0	1,218	0	0	0	0	0	0	0	0	(20,813)	20
21	Clerical & General Office Expenses	(1,061,625)	0	15,206	124,479	0	0	0	0	0	0	0	(921,940)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(4,272)	0	0	0	0	0	0	0	(4,272)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	418	0	0	0	0	0	0	0	0	418	24
25	Other Admin. Staff Transportation	(15,455)	0	1,666	0	0	0	0	0	0	0	0	(13,789)	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,699	0	0	0	0	0	0	0	0	1,699	26
27	Other (specify):*	0	0	0	26,585	0	0	0	0	0	0	0	26,585	27
28	**TOTAL General Administration**	(1,226,655)	9,850	(120,714)	167,576	0	0	0	0	0	0	0	(1,169,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,226,705)	9,850	(110,629)	180,448	0	0	0	0	0	0	0	(1,147,036)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	165,171	2,693	0	0	0	0	0	0	0	0	167,864	30
31	Amortization of Pre-Op. & Org.	(10,915)	10,915	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,673)	282,820	10,833	0	0	0	0	0	0	0	0	291,980	32
33	Real Estate Taxes	0	0	5,429	0	0	0	0	0	0	0	0	5,429	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	994	0	0	0	0	0	0	0	0	994	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,588)	(321,094)	19,949	0	0	0	0	0	0	0	0	(313,733)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(27,607)	0	0	0	0	0	0	0	0	0	0	(27,607)	43
44	**TOTAL Special Cost Centers**	(27,607)	0	0	0	0	0	0	0	0	0	0	(27,607)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,266,900)	(311,244)	(90,680)	180,448	0	0	0	0	0	0	0	(1,488,376)	45

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 780,000	Countryside Healthcare Center, LLC	100.00%	$	$ (780,000)	1
2	V	33	Real Estate Taxes	677,750	Countryside Healthcare Center, LLC	100.00%		(677,750)	2
3	V	17	Management Fees		Countryside Healthcare Center, LLC	100.00%	9,850	9,850	3
4	V	21	Office		Countryside Healthcare Center, LLC	100.00%			4
5	V	21	State Replacement Tax		Countryside Healthcare Center, LLC	100.00%			5
6	V	30	Depreciation		Countryside Healthcare Center, LLC	100.00%	165,171	165,171	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%	282,820	282,820	8
9	V	33	Real Estate Taxes		Countryside Healthcare Center, LLC	100.00%	677,750	677,750	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			$ 1,457,750			$ 1,146,506	$ * (311,244)	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: 01/01/15 Ending: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 194	$ 194	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	517	517	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	1,363	1,363	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	2,066	2,066	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	5,945	5,945	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,714	3,714	20
21	V	19	Professional Fees	151,200	Extended Care Consulting, LLC	100.00%	6,565	(144,635)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,218	1,218	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	15,206	15,206	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	418	418	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,666	1,666	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,699	1,699	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,693	2,693	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	10,833	10,833	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,429	5,429	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	994	994	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			$ 151,200			$ 60,520	$ * (90,680)	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: 01/01/15 Ending: 12/31/15

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%	$ 11,852	$ 11,852	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,020	1,020	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	20,784	20,784	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	124,479	124,479	20
21	V	21	Office and Clerical (Direct)	15,244	Extended Care Consulting, LLC	100.00%	15,244		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	24,937	24,937	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,648	1,648	23
24	V	22	Employee Benefits	4,272	Extended Care Consulting, LLC	100.00%		(4,272)	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			$ 19,516			$ 199,964	$ * 180,448	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: 01/01/15 Ending: 12/31/15

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	$	Care Centers Health Systems, Inc.	100.00%	$	$	15
16	V	10	Nursing		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary		Care Centers Health Systems, Inc.	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Supplies	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	39	Ancillary		Reliable Medical of the Midwest, LLC	100.00%			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: 01/01/15 Ending: 12/31/15

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	$ 178,877	CCS VEBA	100.00%	$ 178,877	$	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			$ 178,877			$ 178,877	$ *	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: 01/01/15 Ending: 12/31/15

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	30	Depreciation	$	Vent Lease, LLC	100.00%	$	$	15
16	V	32	Interest		Vent Lease, LLC	100.00%			16
17	V	39	Ancillary		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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 6,865	MAC Rx, LLC	100.00%	$ 6,865	$	15
16	V	39	Ancillary	29,549	MAC Rx, LLC	100.00%	29,549		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			$ 36,414			$ 36,414	$ *	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: 01/01/15 Ending: 12/31/15

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			Alloc. Salary	$	22 - 07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: Countryside Healthcare Center, LLC
Street Address: 1635 East 154th Street
City / State / Zip Code: Dolton, Illinois 60419
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: 01/01/15 Ending: 12/31/15

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	1,326,152	30	$ 4,390	$	58,641	$ 194	1
2	2	Food	Patient Days	1,326,152	30	11,689		58,641	517	2
3	3	Housekeeping	Patient Days	1,326,152	30	30,827		58,641	1,363	3
4	5	Utilities	Patient Days	1,326,152	30	46,718		58,641	2,066	4
5	6	Maintenance	Patient Days	1,326,152	30	134,435		58,641	5,945	5
6	17	Administrative	Patient Days	1,326,152	30	84,000		58,641	3,714	6
7	19	Professional Fees	Patient Days	1,326,152	30	148,456		58,641	6,565	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	30	27,539		58,641	1,218	8
9	21	Office and Clerical	Patient Days	1,326,152	30	343,869		58,641	15,206	9
10	24	Travel and Seminar	Patient Days	1,326,152	30	9,455		58,641	418	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	30	37,668		58,641	1,666	11
12	26	Insurance	Patient Days	1,326,152	30	38,431		58,641	1,699	12
13	30	Depreciation	Patient Days	1,326,152	30	60,912		58,641	2,693	13
14	32	Interest	Patient Days	1,326,152	30	244,990		58,641	10,833	14
15	33	Real Estate Taxes	Patient Days	1,326,152	30	122,786		58,641	5,429	15
16	35	Rent - Equipment and Auto	Patient Days	1,326,152	30	22,475		58,641	994	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 60,520	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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) 941 - 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	1,326,152	30	$ 268,019	$ 268,019	58,641	$ 11,852	1
2	6	Maintenance	Direct	1	1	10,126	10,126			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,326,152	30	23,065		58,641	1,020	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1	853				4
5	17	Administrative	Patient Days	1,326,152	30	470,018	470,018	58,641	20,784	5
6	21	Office and Clerical	Patient Days	1,326,152	30	2,815,061	2,815,061	58,641	124,479	6
7	21	Office and Clerical	Direct	1	1	15,244	15,244	1	15,244	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,326,152	30	563,937		58,641	24,937	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	1,648		1	1,648	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					$ 4,167,971	$ 3,578,468		$ 199,964	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 %			$	$		$	1
2	10	Nursing	Profit Margin %							2
3	39	Ancillary	Profit Margin %							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: 01/01/15 Ending: 12/31/15

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	10A	Therapy Consultant	Profit Margin %	1,000	10	$ 1,000	$		$	1
2	22	Employee Benefits	Profit Margin %	102	10	102				2
3	39	Therapy	Profit Margin %	5,693,928	10	5,693,928				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					$ 5,695,030	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing Supplies	Profit Margin %	12,664	3	$ 9,098	$		$	1
2	39	Ancillary Expense	Profit Margin %	725	3	521				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					$ 9,619	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	6,316,950	30	$ 6,316,950	$	178,877	$ 178,877	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					$ 6,316,950	$		$ 178,877	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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) 941 - 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	30	Depreciation	Direct			$	$		$	1
2	32	Interest	Direct							2
3	39	Ancillary	Profit Margin %	125,445	16	125,445				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					$ 125,445	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 Mount Prospect Road
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 220 - 2700
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	10	Nursing and Medical Records	Profit Margin %	248,335	20	$ 248,335	$	6,865	$ 6,865	1
2	39	Ancillary	Profit Margin %	1,903,063	20	1,903,063		29,549	29,549	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					$ 2,151,398	$		$ 36,414	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 6,390,227			$ 282,820	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							27,085	6
7	Alloc. - Extended Care Cons.	X		Line of Credit							10,833	7
8												8
9	TOTAL Facility Related						$ 7,100,000	$ 6,390,227			$ 320,738	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(1,673)	12
13	Interest Income - Bldg Part.		X									13
14	TOTAL Non-Facility Related						$	$			$ (1,673)	14
15	TOTALS (line 9+line14)						$ 7,100,000	$ 6,390,227			$ 319,065	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Countryside Nrsg & Rehab Ctr **#** 0050708 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	592,174	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.)	$	624,904	2
3. Under or (over) accrual (line 2 minus line 1).	$	32,730	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	650,449	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.)**	$	34,409	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	717,588	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	449,999	8
	2011	757,033	9
	2012	561,600	10
	2013	563,975	11
	2014	619,475	12

2015 Real Estate Tax Accrual = $619,475 * 1.05 = $650,449

Extended Care Consulting, LLC (Allocations) = $5,429

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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

2014 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

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 2014 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 2014.

	(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	$ 619,475.03	$ 619,475.03
2.	Alloc. - Ext. Care Consulting	Long Term Care Facility	$ 116,110.42	$ 5,134.28
3.	Alloc. - Ext. Care Consulting	Long Term Care Facility	$ 3,814.66	$ 168.68
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 739,400.11	$ 624,777.99

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			25,375	2
3	TOTALS			$ 418,125	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						26
27	Various			2011	21,657						27
28	D Wing - Base, Drywall, Tape, Paint, Tile and Adhesive			2012	6,779						28
29	SS Office - Base, Drywall, Tape, Paint, and Locks			2012	1,622						29
30	Reception Area - Tile and Adhesive			2012	2,763						30
31	Hallways - Tile and Adhesive, Concrete			2012	13,924						31
32	B Wing - Tile and Adhesive, Base, Drywall, Handrail, and Paint			2012	21,761						32
33	Smokehouse - Storage Unit, Electric, Door, and Locks			2012	18,862						33
34	Dining Room - Electrical and Paint			2012	2,683						34
35	Kitchen - Paint			2012	2,219						35
36	Hot Water Tank			2012	3,290						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: 01/01/15 Ending: 12/31/15

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	Concrete - Outside Back of Building	2013	$ 4,350	$		$	$	$	37
38	Flooring - Dining Room	2013	14,944						38
39	Roof	2013	84,500						39
40	Heat Exchanger - Roof	2013	4,959						40
41	Doors - Delayed Egress Mag Lock	2014	3,573						41
42	Sprinkler System	2014	11,500						42
43	Drywall - Wings	2014	18,000						43
44	Drywall, Handrail, and Wallguards Installation	2015	3,406						44
45	Drywall, Handrail, and Wallguards Installation	2015	5,509						45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61	Countryside Healthcare Center, LLC								61
62									62
63	Building	1977	5,408,525						63
64	Various	2001	256,048						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,588,805	$		$	$	$	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: 01/01/15 Ending: 12/31/15

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		$ 6,588,805	$		$	$	$	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting, LLC	2007	203	10		10		92	5
6	Allocations - Extended Care Consulting, LLC	2009	122	6		6		43	6
7	Allocations - Extended Care Consulting, LLC	2010	1,193	60		60		358	7
8	Allocations - Extended Care Consulting, LLC	2011	429	21		21		107	8
9	Allocations - Extended Care Consulting, LLC	2013	142	7		7		28	9
10	Allocations - Extended Care Consulting, LLC	2014	1,961	98		98		196	10
11									11
12									12
13	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	34,968	897		897		11,918	13
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	28,887					28,887	14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	34,042					34,042	15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	1,691	180		180		1,688	16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	305	15		15		107	17
18	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	2,838	142		142		284	18
19	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	481	24		24		24	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation - Countryside Nursing & Rehab Center, LLC			12,828		12,828		35,579	31
32	Depreciation - Countryside Healthcare Center, LLC			165,171		165,171		4,008,140	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,696,067	$ 179,459		$ 179,459	$	$ 4,121,493	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: 01/01/15 Ending: 12/31/15

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	$ 76,222	$ 17,487	$ 17,487	$		$ 48,669	71
72	Current Year Purchases	77,329	9,850	9,850			9,850	72
73	Fully Depreciated Assets							73
74	R.P. Allocations	539,098	1,008	1,008			533,191	74
75	TOTALS	$ 692,649	$ 28,345	$ 28,345	$		$ 591,710	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 Consulting			$ 7,980	$ 225	$ 225	$		$ 7,304	76
77										77
78										78
79										79
80	TOTALS			$ 7,980	$ 225	$ 225	$		$ 7,304	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)	$ 7,814,821	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,029	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,029	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)	$ 4,720,507	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	Book Depr.	S/L Depr.	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, Inc.				
Prior	134,052	872	872	129,372
Current	1,363	136	136	136
Total	135,415	1,008	1,008	129,508
Related Party 3 - Extended Care Consulting, Inc. / Care Centers Building, LLC				
Prior	9,683			9,683
Current				
Total	9,683	-	-	9,683
Related Party 4 -				
Prior				
Current				
Total	-	-	-	-
Total	**539,098**	**1,008**	**1,008**	**533,191**

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Suppl.				1,731			5
6								6
7	TOTAL				$ 1,731 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 10,863 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	$	$ 10,652	17
18					18
19					19
20					20
21	TOTAL		$	$ 10,652	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
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Mobile Mini, Inc.	1,731
Total	1,731

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Aqua Coolers	816
Hughes Enterprises, Inc.	5,060
Neopost USA, Inc.	117
US Gas	66
Xeros Financial Services	3,810
Alloc. - Extended Care Consulting	994
Total	10,863

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 251,355	$		$ 251,355	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			66,261			66,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			259,838			259,838	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				131,809		131,809	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					7,407		7,407	12
13	Other (specify): See Supplemental	39 - 03				23,957			23,957	13
14	TOTAL			$		$ 601,411	$ 139,216		$ 740,627	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 Nursing & Rehab Center, LLC
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Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	3,175	
Oxgyen	2,502	
Low Pressure Mattress	725	
Laboratory		7,954
Radiology		2,465
Ambulance		
Other Services	1,005	13,538
Total	7,407	23,957

STATE OF ILLINOIS

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 50,654	$ 167,882	1
2	Cash-Patient Deposits	118,211	118,211	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,117,182)	1,689,710	1,689,710	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	308,881	308,881	6
7	Other Prepaid Expenses	44,871	44,871	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	3,296	344,007	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,215,623	$ 2,673,562	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	242,971	499,019	15
16	Equipment, at Historical Cost	178,172	572,172	16
17	Accumulated Depreciation (book methods)	(94,098)	(4,496,238)	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		1,883,111	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 327,045	$ 4,259,339	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,542,668	$ 6,932,901	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,146,301	$ 2,146,301	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	118,211	118,211	28
29	Short-Term Notes Payable	360,740	360,740	29
30	Accrued Salaries Payable	260,521	260,521	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,763	8,763	31
32	Accrued Real Estate Taxes(Sch.IX-B)		650,449	32
33	Accrued Interest Payable		8,396	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	755,354		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,649,890	$ 3,553,381	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,974	14,974	39
40	Mortgage Payable		6,390,227	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)**	$ 14,974	$ 6,405,201	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,664,864	$ 9,958,582	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,122,196)	$ (3,025,681)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,542,668	$ 6,932,901	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Countryside Nursing & Rehab Center, LLC
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Deposits	2,280	2,280
Due from Employees	1,016	1,016
Real Estate Tax Deposit		340,711
Total	3,296	344,007
Line 23 - Other Long Term Assets		
Due from Affiliated Entities		1,851,275
Financing Costs (Net of Amortization)		31,836
Total	-	1,883,111
Line 36 - Other Current Liabilities		
Due to Affiliated Entities	755,354	
Total	755,354	-
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,184,611	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,184,611	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,182,726	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	(4,489,533)	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)**	$ (3,306,807)	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)**	$ (1,122,196)	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: 01/01/15 Ending: 12/31/15

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	$ 10,951,020	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,951,020	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	172,036	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 172,036	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***	1,673	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,673	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,124,729	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,372,364	31
32	Health Care	2,801,045	32
33	General Administration	3,013,332	33
	B. Capital Expense		
34	Ownership	1,547,252	34
	C. Ancillary Expense		
35	Special Cost Centers	768,234	35
36	Provider Participation Fee	439,776	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,942,003	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,182,726	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,182,726	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,842,144	44
45	Private Pay - Net Inpatient Revenue	10,855	45
46	Medicare - Net Inpatient Revenue	2,009,136	46
47	Other-(specify) Hospice - Net Inpatient Revenue	38,832	47
48	Other-(specify) Insurance - Net Inpatient Revenue	1,050,053	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,951,020	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

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,100	2,217	$ 100,969	$ 45.54	1
2	Assistant Director of Nursing	1,626	1,882	80,171	42.60	2
3	Registered Nurses	8,931	9,759	288,724	29.59	3
4	Licensed Practical Nurses	28,471	30,739	723,009	23.52	4
5	CNAs & Orderlies	57,980	64,396	640,835	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,957	5,893	107,407	18.23	8
9	Activity Director	1,887	2,094	33,288	15.90	9
10	Activity Assistants	7,847	8,682	83,139	9.58	10
11	Social Service Workers	14,984	16,495	286,221	17.35	11
12	Dietician					12
13	Food Service Supervisor	1,932	2,078	39,925	19.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,994	19,250	201,065	10.44	15
16	Dishwashers					16
17	Maintenance Workers	5,382	5,992	99,390	16.59	17
18	Housekeepers	21,288	23,626	229,658	9.72	18
19	Laundry	4,225	4,729	46,129	9.75	19
20	Administrator	1,826	2,038	114,485	56.18	20
21	Assistant Administrator	1,914	2,086	59,772	28.65	21
22	Other Administrative	2,098	2,291	125,123	54.62	22
23	Office Manager					23
24	Clerical	9,997	11,117	239,830	21.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	48	55	1,851	33.65	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,876	2,089	23,963	11.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,954	10,887	293,931	27.00	33
34	TOTAL (lines 1 - 33)	206,317	228,395	$ 3,818,885 *	$ 16.72	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		$ 11,413	01 - 03	35
36	Medical Director		12,000	09 - 03	36
37	Medical Records Consultant		11,142	10 - 03	37
38	Nurse Consultant		29,843	10 - 03	38
39	Pharmacist Consultant		2,283	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		320	10.1-03	43
44	Activity Consultant		848	11 - 03	44
45	Social Service Consultant		824	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 68,673		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

Countryside Nursing & Rehab Center, LLC
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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Security (Line 7)	3,525	3,812	40,292
MDS / Care Plan Coordinator (Line 10)	3,732	4,130	106,917
Quality Assurance (Line 10)	1,426	1,478	49,957
MDS Coordinator (Line 10)	792	941	69,158
Marketing (Line 43)	479	526	27,607
Total	9,954	10,887	293,931

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Callie Graham	Administrator	0	$ 114,485
Angela Noland	Asst. Admin.	0	59,772
Loren Summerfield	Administration	0	43,472
Sherwin Ray	Administration	0	81,651
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 299,380

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	$ 151,200
Plante Moran, PLLC	Accounting	24,675
Frost, Ruttenberg & Rothblatt, PC	Accounting	3,249
Personnel Planners, Inc.	Unemployment	1,695
Grabowski Law Center, LLC	Collections	3,596
Paycor Payroll Services	Data Processing	22,087
E-Health Data Solutions	Data Processing	8,270
American Data	Data Processing	2,768
National Datacare Corporation	Data Processing	3,869
Matrix Care	Data Processing	29,386
Emdeon Business Services	Data Processing	1,011
See Supplemental Schedule	See Supplemental Schedule	181,084
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 432,890

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,268
Unemployment Compensation Insurance	57,445
FICA Taxes	252,427
Employee Health Insurance	153,229
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	18,754
TOTAL (agree to Schedule V, line 22, col.8)	$ 565,123

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	16,352
Health Care Worker Background Check	2,710
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	10,935
Licenses	3,891
Advertising and Promotion	22,031
Alloc. - Extended Care Consulting	1,218
Less: Public Relations Expense	( )
Non-allowable advertising	(22,031)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,114
Alloc. - Extended Care Consulting	418
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,532

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Description of Services	Total
Comcast	Data Processing	1,284
Ability Network	Data Processing	1,108
Tad Nelson Consulting	Data Processing	2,475
Microsoft	Data Processing	1,087
Other	Data Processing	65
Generation Law	Legal	1,899
Huston, May & Fayez	Legal	18,819
Finkel, Martwick & Colson	Legal	34,409
O'Hagan	Legal	711
Care Management Facility	Other	129
Robbins, Solomon & Pratt	Other	5,000
Non-Allowable	Legal	20,034
Non-Allowable	Other	94,064
Sub-Total		181,084

Countryside Nursing & Rehab Center, LLC
Medicaid Cost Report
01/01/15 - 12/31/15

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Allowable
Generation Law	06/19/15	Resident GAL	1,899	1,899
Huston, May & Fayez	01/31/15	Corporate Matters	293	293
Huston, May & Fayez	02/23/15	Corporate Matters	248	248
Huston, May & Fayez	03/18/15	Corporate Matters	630	630
Huston, May & Fayez	03/18/15	Corporate Matters	825	825
Huston, May & Fayez	04/30/15	Corporate Matters	248	248
Huston, May & Fayez	04/30/15	Corporate Matters	360	360
Huston, May & Fayez	07/24/15	Corporate Matters	275	275
Huston, May & Fayez	07/24/15	Corporate Matters	1,415	1,415
Huston, May & Fayez	07/24/15	Corporate Matters	485	485
Huston, May & Fayez	07/24/15	Corporate Matters	4,592	4,592
Huston, May & Fayez	09/22/15	Corporate Matters	156	156
Huston, May & Fayez	09/22/15	Corporate Matters	3,371	3,371
Huston, May & Fayez	09/22/15	Corporate Matters	2,157	2,157
Huston, May & Fayez	09/22/15	Corporate Matters	405	405
Huston, May & Fayez	09/22/15	Corporate Matters	639	639
Huston, May & Fayez	11/30/15	Corporate Matters	705	705
Huston, May & Fayez	11/30/15	Corporate Matters	261	261
Huston, May & Fayez	11/30/15	Corporate Matters	171	171
Huston, May & Fayez	11/30/15	Corporate Matters	1,583	1,583
O'Hagan	07/31/15	Corporate Matters	48	48
O'Hagan	07/31/15	Corporate Matters	240	240
O'Hagan	07/31/15	Corporate Matters	423	423
Finkel, Martwick & Colson	03/31/15	RE Tax Assessment Appeal	34,409	34,409
Non-Allowable		Non-Allowable	20,034	
Total			75,872	55,838
Allowable				

Facility Name & ID Number Countryside Nrsg & Rehab Ctr # 0050708 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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: 01/01/15 Ending: 12/31/15

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? **Yes**
If YES, give association name and amount. **ICLTC - $10,000**

(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. $ **55** 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. $ **439,776**
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. $ **0**

(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? **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