FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0050708

Facility Name: Countryside Nursing & Rehabilitation Center, LLC

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 12/16/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 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, 200 N. Martingale Road, Suite 900 Schaumburg, IL 60173
(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' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	27,739	1,215	3,587	32,541	8
9	SNF/PED					9
10	ICF	26,907	256		27,163	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,646	1,471	3,587	59,704	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.03%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 3,158

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	249,529	27,945	8,615	286,089		286,089	220	286,309			1
2	Food Purchase		370,145		370,145		370,145	(856)	369,289			2
3	Housekeeping	240,324	48,184		288,508		288,508	1,330	289,838			3
4	Laundry	76,507	17,551		94,058		94,058		94,058			4
5	Heat and Other Utilities			177,767	177,767		177,767	1,648	179,415			5
6	Maintenance	98,703		121,833	220,536		220,536	14,278	234,814			6
7	Other (specify):* See Supplemental	44,755		191	44,946		44,946	903	45,849			7
8	**TOTAL General Services**	709,818	463,825	308,406	1,482,049		1,482,049	17,523	1,499,572			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,341,189	104,380	15,360	2,460,929		2,460,929		2,460,929			10
10a	Therapy	85,074			85,074		85,074		85,074			10a
11	Activities	135,086	14,594	848	150,528		150,528		150,528			11
12	Social Services	329,706	25,374	2,325	357,405		357,405		357,405			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	2,891,055	144,348	30,533	3,065,936		3,065,936		3,065,936			16
	C. General Administration											
17	Administrative	285,777			285,777		285,777	22,928	308,705			17
18	Directors Fees											18
19	Professional Services			350,984	350,984		350,984	(279,257)	71,727			19
20	Dues, Fees, Subscriptions & Promotions			65,552	65,552		65,552	(14,032)	51,520			20
21	Clerical & General Office Expenses	296,831	11,308	593,689	901,828		901,828	(415,741)	486,087			21
22	Employee Benefits & Payroll Taxes			674,295	674,295		674,295	10,612	684,907			22
23	Inservice Training & Education			1,894	1,894		1,894		1,894			23
24	Travel and Seminar			4,796	4,796		4,796	42	4,838			24
25	Other Admin. Staff Transportation			14,094	14,094		14,094	976	15,070			25
26	Insurance-Prop.Liab.Malpractice			276,075	276,075		276,075	1,987	278,062			26
27	Other (specify):* See Supplemental							29,059	29,059			27
28	**TOTAL General Administration**	582,608	11,308	1,981,379	2,575,295		2,575,295	(643,426)	1,931,869			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,183,481	619,481	2,320,318	7,123,280		7,123,280	(625,903)	6,497,377			29

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

SEE ACCOUNTANTS' PREPARATION 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 & Rehabilitation Center, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Security	44,755		191	44,946
				-
Alloc - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			903	903
				-
				-
				-
Sub-Total	44,755	-	1,094	45,849
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 27 - Other General Administration				
Alloc - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			29,059	29,059
				-
				-
				-
				-
				-
Sub-Total	-	-	29,059	29,059

Countryside Nursing & Rehabilitation Center, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
American Express	Business Matters	Various	Various	1,581			1,581
Beraiah Henton	Business Matters	Various	Various	25			25
Callie Graham	Business Matters	Various	Various	46			46
Care Management Facility, Llc.	Business Matters	Various	Various	5,894			5,894
Carol Sudol	Business Matters	Various	Various	1,095			1,095
City Of Chicago	Business Matters	Various	Various	125			125
Donna Gray	Business Matters	Various	Various	1,814			1,814
Illinois Tollway	Business Matters	Various	Various	65			65
Lamont Taylor	Business Matters	Various	Various	2,376			2,376
Lorena Robledo-Sommerfield	Business Matters	Various	Various	921			921
Sandra Hines	Business Matters	Various	Various	152			152
							-
Alloc - Extended Care Consulting, LLC				1,101			1,101
							-
Non-Allowable				(125)			(125)
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				15,070	-	-	15,070

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC #0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			50,729	50,729		50,729	167,995	218,724			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,370	1,370		1,370	249,714	251,084			32
33	Real Estate Taxes			688,856	688,856		688,856	4,964	693,820			33
34	Rent-Facility & Grounds			782,313	782,313		782,313	(780,000)	2,313			34
35	Rent-Equipment & Vehicles			16,916	16,916		16,916	1,217	18,133			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,540,184	1,540,184		1,540,184	(356,110)	1,184,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,657	374,134	460,791		460,791		460,791			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			453,993	453,993		453,993		453,993			42
43	Other (specify):* See Supplemental	31,729			31,729		31,729	(31,729)				43
44	TOTAL Special Cost Centers	31,729	86,657	828,127	946,513		946,513	(31,729)	914,784			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,215,210	706,138	4,688,629	9,609,977		9,609,977	(1,013,742)	8,596,235			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Countryside Nursing & Rehabilitation Center, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 4 Supplemental Schedule

Line 36 - Other Capital Costs

Description	Salaries	Supplies	Other	Total
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Line 43 - Other Special Cost Centers

Non-Allowable	31,729			31,729
				-
				-
				-
				-
				-
				-
Sub-Total	31,729	-	-	31,729

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(18,260)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,499)	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	(16,250)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(527,901)	21		24
25	Fund Raising, Advertising and Promotional	(15,019)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(188,549)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (767,478)		$	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)	(246,264)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (246,264)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,013,742)		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' PREPARATION REPORT

STATE OF ILLINOIS

Countryside Nursing & Rehabilitation Center, LLC

ID# 0050708

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal - Non Allowable	$ (10,744)	19	1
2	Professional - Non Allowable	(121,680)	19	2
3	Theft Loss	(26)	21	3
4	Bank Charges	(3,479)	21	4
5	Fine	(125)	25	5
6	Non-Allowable	(31,729)	43	6
7				7
8				8
9				9
10	Countryside Healthcare Center, LLC			10
11	Professional Fees	(9,850)	19	11
12	Office	(1)	21	12
13	Amortization	(10,915)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(188,549)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	220	0	0	0	0	0	0	0	0	220	1
2	Food Purchase	(1,499)	0	643	0	0	0	0	0	0	0	0	(856)	2
3	Housekeeping	0	0	1,330	0	0	0	0	0	0	0	0	1,330	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,648	0	0	0	0	0	0	0	0	1,648	5
6	Maintenance	0	0	4,539	9,739	0	0	0	0	0	0	0	14,278	6
7	Other (specify):*	0	0	0	903	0	0	0	0	0	0	0	903	7
8	**TOTAL General Services**	(1,499)	0	8,380	10,642	0	0	0	0	0	0	0	17,523	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	3,397	19,531	0	0	0	0	0	0	0	22,928	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(142,274)	9,850	(146,833)	0	0	0	0	0	0	0	0	(279,257)	19
20	Fees, Subscriptions & Promotions	(15,019)	0	987	0	0	0	0	0	0	0	0	(14,032)	20
21	Clerical & General Office Expenses	(547,657)	1	9,760	122,155	0	0	0	0	0	0	0	(415,741)	21
22	Employee Benefits & Payroll Taxes	0	0	0	10,612	0	0	0	0	0	0	0	10,612	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	42	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	(125)	0	1,101	0	0	0	0	0	0	0	0	976	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,987	0	0	0	0	0	0	0	0	1,987	26
27	Other (specify):*	0	0	0	29,059	0	0	0	0	0	0	0	29,059	27
28	**TOTAL General Administration**	(705,075)	9,851	(129,559)	181,357	0	0	0	0	0	0	0	(643,426)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(706,574)	9,851	(121,179)	191,999	0	0	0	0	0	0	0	(625,903)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC **#** 0050708 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	165,170	2,825	0	0	0	0	0	0	0	0	167,995	30
31	Amortization of Pre-Op. & Org.	(10,915)	10,915	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,260)	250,282	17,692	0	0	0	0	0	0	0	0	249,714	32
33	Real Estate Taxes	0	0	4,964	0	0	0	0	0	0	0	0	4,964	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	1,217	0	0	0	0	0	0	0	0	1,217	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,175)	(353,633)	26,698	0	0	0	0	0	0	0	0	(356,110)	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):*	(31,729)	0	0	0	0	0	0	0	0	0	0	(31,729)	43
44	**TOTAL Special Cost Centers**	(31,729)	0	0	0	0	0	0	0	0	0	0	(31,729)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(767,478)	(343,782)	(94,481)	191,999	0	0	0	0	0	0	0	(1,013,742)	45

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	32	Interest		Countryside Healthcare Center, LLC	100.00%			2
3	V	19	Professional Fees		Countryside Healthcare Center, LLC	100.00%	9,850	9,850	3
4	V	21	Office		Countryside Healthcare Center, LLC	100.00%	1	1	4
5	V	26	Property Insurance		Countryside Healthcare Center, LLC	100.00%			5
6	V	30	Depreciation		Countryside Healthcare Center, LLC	100.00%	165,170	165,170	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%	250,282	250,282	8
9	V	33	Real Estate Taxes	688,856	Countryside Healthcare Center, LLC	100.00%	688,856		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			$ 1,468,856			$ 1,125,074	$ * (343,782)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				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	HC Center, LLC	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

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 220	$ 220	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	643	643	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	1,330	1,330	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	1,648	1,648	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	4,539	4,539	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,397	3,397	20
21	V	19	Professional Fees	151,200	Extended Care Consulting, LLC	100.00%	4,367	(146,833)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	987	987	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,760	9,760	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	42	42	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,101	1,101	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,987	1,987	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,825	2,825	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	17,692	17,692	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	4,964	4,964	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	1,217	1,217	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			$ 56,719	$ * (94,481)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 9,739	$ 9,739	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%	903	903	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%	19,531	19,531	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	122,155	122,155	20
21	V	21	Office and Clerical (Direct)	19,944	Extended Care Consulting, LLC	100.00%	19,944		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,377	27,377	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,682	1,682	23
24	V	22	Employee Benefits	(10,612)	Extended Care Consulting, LLC	100.00%		10,612	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			$ 9,332			$ 201,331	$ * 191,999	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 268,606	CCS VEBA	100.00%	$ 268,606	$	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			$ 268,606			$ 268,606	$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Cente # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Supplemental	1.19	2.98%	Alloc. Salary	$ 2,064	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	$ 2,064		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

Countryside Nursing & Rehabilitation Center, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 7 Supplemental Schedule

Desciption	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation Salary	Total Compensation Emp. Benefits	Alloc. Compensation Salary	Alloc. Compensation Emp. Benefits
Owners / Director Compensation							
Adam Vales						-	-
Timber Point Healthcare Center	0.88	40.00	2.19%	69,194	-	1,515	-
Prairie Village Healthcare Center	0.59	40.00	1.47%	69,194	-	1,020	-
Countryside Nursing & Rehab	1.19	40.00	2.98%	69,194	-	2,064	-
Kensington Place Nursing & Rehab	1.02	40.00	2.56%	69,194	-	1,768	-
Little Village	0.14	40.00	0.35%	69,194	-	240	-
Park House Nursing & Rehab	0.20	40.00	0.51%	69,194	-	350	-
Rushville Nursing & Rehab	0.55	40.00	1.37%	69,194	-	951	-
Other Entities	35.43	40.00	88.57%	69,194	-	61,286	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
Total	40		100.00%			69,194	-

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	59,704	$ 220	1
2	2	Food	Patient Days	1,476,506	37	15,903		59,704	643	2
3	3	Housekeeping	Patient Days	1,476,506	37	32,901		59,704	1,330	3
4	5	Utilities	Patient Days	1,476,506	37	40,755		59,704	1,648	4
5	6	Maintenance	Patient Days	1,476,506	37	112,249		59,704	4,539	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		59,704	3,397	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		59,704	4,367	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		59,704	987	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		59,704	9,760	9
10	24	Travel and Seminar	Patient Days	1,476,506	37	1,048		59,704	42	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		59,704	1,101	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		59,704	1,987	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		59,704	2,825	13
14	32	Interest	Patient Days	1,476,506	37	437,528		59,704	17,692	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		59,704	4,964	15
16	35	Rent - Equipment and Auto	Patient Days	1,476,506	37	30,092		59,704	1,217	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 56,719	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 240,841	$ 240,841	59,704	$ 9,739	1
2	6	Maintenance	Direct	358,056	37	358,056	358,056			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,476,506	37	22,330		59,704	903	3
4	7	Emp. Ben. - Gen. Serv.	Direct	51,193	37	51,193				4
5	17	Administrative	Patient Days	1,476,506	37	483,002	483,002	59,704	19,531	5
6	21	Office and Clerical	Patient Days	1,476,506	37	3,020,951	3,020,951	59,704	122,155	6
7	21	Office and Clerical	Direct	498,631	37	498,631	498,631	19,944	19,944	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,476,506	37	677,040		59,704	27,377	8
9	27	Emp. Gen. - Gen. Admin.	Direct	74,203	37	74,203		1,682	1,682	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					$ 5,426,247	$ 4,601,481		$ 201,331	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Allocation	9,005,461	37	$ 9,005,461	$	268,606	$ 268,606	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					$ 9,005,461	$		$ 268,606	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Cente # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$ 5,616,853			$ 250,282	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							1,370	6
7	Alloc. - Extended Care		X	Line of Credit							17,692	7
8												8
9	TOTAL Facility Related						$	$ 5,616,853			$ 269,344	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(18,260)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (18,260)	14
15	TOTALS (line 9+line14)						$	$ 5,616,853			$ 251,084	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' PREPARATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC **#** 0050708 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	674,497	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.)	$	670,014	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,483)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	698,303	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	693,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	561,600	8
	2013	563,975	9
	2014	619,475	10
	2015	642,378	11
	2016	665,050	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2017 Real Estate Tax Accrual = $665,050 * 1.05 = $698,303

Alloc. - Extended Care Consulting, LLC = $4,964

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryside Nursing & Rehabilitation Center, LLC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050708

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 665,050.34	$ 665,050.34
2.	Alloc. - Ext. Care Consulting	Long Term Care Facility	$ 181,041.32	$ 4,964.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 846,091.66	$ 670,014.62

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			22,485	2
3	TOTALS			$ 415,235	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Various			2012	73,903						28
29	Various			2013	108,753						29
30	Doors - Delayed Egress Mag Lock			2014	3,573						30
31	Sprinkler System			2014	11,500						31
32	Drywall - Wings			2014	18,000						32
33	Drywall, Handrail, and Wallguards Intallation			2015	8,915						33
34	Flooring - Resident Rooms			2016	22,796						34
35	Illuminated Sign - Exterior			2016	5,200						35
36	Roof Repairs			2016	3,725						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' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Parking Lot - Pave and Seal	2016	$ 34,377	$		$	$	$	37
38	Doors - Dining Room	2016	3,643						38
39	Electrical Panel - Wire Transfer	2016	9,500						39
40	Call Light System - Resident Rooms	2016	10,925						40
41	Electrical Panel - Install 2 New Ampere 120 Volt Circuits	2017	10,200						41
42	Painting - Spot Areas	2017	2,860						42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54	Countryside Healthcare Center, LLC								54
55	Building	1977	5,408,525						55
56	Various	2001	256,048						56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,692,031	$		$	$	$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 6,692,031	$		$	$	$	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting, LLC	2007	186						5
6	Allocations - Extended Care Consulting, LLC	2009	111						6
7	Allocations - Extended Care Consulting, LLC	2010	1,091						7
8	Allocations - Extended Care Consulting, LLC	2011	393						8
9	Allocations - Extended Care Consulting, LLC	2012	129						9
10	Allocations - Extended Care Consulting, LLC	2014	1,793						10
11	Allocations - Extended Care Consulting, LLC	2016	2,150						11
12	Allocations - Extended Care Consulting, LLC	2017							12
13									13
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	30,985						14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	25,596						15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	30,164						16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	1,499						17
18	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	270						18
19	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	2,596						19
20	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	426						20
21	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	1,684						21
22	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2017	2,921						22
23									23
24	Allocations - Extended Care Consulting, LLC / Dyer Building	2007	9,705						24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation - Countryside Nursing & Rehabilitation Center			50,729		50,729		195,679	31
32	Depreciation - Countryside Healthcare Center, LLC			165,170		165,170		4,732,435	32
33	Depreciation - Extended Care Consulting, LLC			2,825		2,825		210,042	33
34	TOTAL (lines 1 thru 33)		$ 6,803,730	$ 218,724		$ 218,724	$	$ 5,138,156	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 189,756	$	$	$		$	71
72	Current Year Purchases	22,341						72
73	Fully Depreciated Assets							73
74	See Supplemental	526,410						74
75	TOTALS	$ 738,507	$	$	$		$	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. - Extended Care			$ 7,297	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 7,297	$	$	$		$	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)	$ 7,964,769	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 218,724	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,724	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)	$ 5,138,156	85

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

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

G. Construction-in-Progress

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

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

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

Countryside Nursing & Rehabilitation Center, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 13 - Related Party Furniture and Equipment Allocations

Desciption	Acquisiton Date	Grouping		Cost
Countryside Healthcare Center, LLC	Prior	Furn. & Equipment		394,000
Extended Care Consulting, LLC	Prior	Furn. & Equipment		9,217
Extended Care Consulting, LLC	Current	Furn. & Equipment		-
Extended Care Consulting, LLC	Full	Furn. & Equipment		114,613
Extended Care Consulting, LLC	Full	Furn. & Equipment		8,580
				526,410

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	See Suppl.				2,313			5
6								6
7	TOTAL				$ 2,313 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,729 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	$	$ 8,404	17
18					18
19					19
20					20
21	TOTAL		$	$ 8,404	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' PREPARATION REPORT

Countryside Nursing & Rehabilitation Center, LLC
Medicaid Cost Report
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Page 14 Supplemental Schedule

Desciption		Amount		Total
Building Rental				
Mobile Mini, Inc.		2,313		2,313
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		2,313		2,313
Equipment Rental				
Aqua Coolers		816		816
Xerox Financial Services		3,475		3,475
Neopost Usa Inc		128		128
Hinkley Spring Water		576		576
Toshiba Financial Services		3,517		3,517
				-
Alloc - Extended Care Consulting, LLC		1,217		1,217
				-
				-
				-
				-
				-
				-
Total		9,729		9,729

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 159,635	$		$ 159,635	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,521			5,521	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			189,025			189,025	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				75,880		75,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					10,777		10,777	12
13	Other (specify): See Supplemental	39 - 03				19,953			19,953	13
14	TOTAL			$		$ 374,134	$ 86,657		$ 460,791	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' PREPARATION REPORT

Countryside Nursing & Rehabilitation Center, LLC
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Therapy and Rehab Supplies		4,241		4,241
Oxygen		6,536		6,536
Food Pump			9,512	9,512
Laboratory			8,255	8,255
Radiology			2,186	2,186
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
Total	-	10,777	19,953	30,730

STATE OF ILLINOIS

Facility Name & ID Number Countryside Nursing & Rehabilitation Center, LLC # 0050708 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$ 3,309	$ 232,685	1
2	Cash-Patient Deposits	36,721	36,721	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,007,212)	1,037,942	1,037,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,754	77,754	6
7	Other Prepaid Expenses	3,281	3,281	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	26,190	30,265	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,185,197	$ 1,418,648	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	328,897	584,945	15
16	Equipment, at Historical Cost	211,437	605,437	16
17	Accumulated Depreciation (book methods)	(195,679)	(4,928,114)	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	344,405	3,111,476	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 689,060	$ 5,175,019	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,874,257	$ 6,593,667	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,861	$ 388,861	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,577	44,577	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,414	333,414	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,513	11,513	31
32	Accrued Real Estate Taxes(Sch.IX-B)		332,525	32
33	Accrued Interest Payable		7,380	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 778,365	$ 1,118,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,616,853	39
40	Mortgage Payable			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)**	$	$ 5,616,853	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 778,365	$ 6,735,123	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,095,892	$ (141,456)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,874,257	$ 6,593,667	48

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***(See instructions.)**

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Description	Operating	Building	Total
Line 9 - Other Current Assets			
Medicare Settlement	26,190		26,190
State Replacement Tax Benefit		4,075	4,075
			-
			-
			-
Sub-Total	26,190	4,075	30,265
Line 23 - Long Term Assets			
Due from Affiliated Entities	344,405	2,757,065	3,101,470
Financing Costs (Net of Amortization)		10,006	10,006
			-
			-
			-
Sub-Total	344,405	2,767,071	3,111,476
Line 36 - Other Current Liability			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 159,937	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 159,937	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,331,014	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	(395,059)	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)**	$ 935,955	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)**	$ 1,095,892	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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	$ 10,813,407	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,813,407	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	109,318	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 109,318	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	6	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,260	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)**	$ 10,940,991	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,482,049	31
32	Health Care	3,065,936	32
33	General Administration	2,575,295	33
	B. Capital Expense		
34	Ownership	1,540,184	34
	C. Ancillary Expense		
35	Special Cost Centers	492,520	35
36	Provider Participation Fee	453,993	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,609,977	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,331,014	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,331,014	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,518,710	44
45	Private Pay - Net Inpatient Revenue	246,237	45
46	Medicare - Net Inpatient Revenue	1,713,064	46
47	Other-(specify) Insurance - Net Inpatient Revenue	193,607	47
48	Other-(specify) Hospice - Net Inpatient Revenue	141,789	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,813,407	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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' PREPARATION REPORT

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Description	Amount	Total
N/A		-
		-
		-
		-
		-
		-
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		-
		-
		-
		-
		-
		-
Total	-	-

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,925	2,102	$ 102,896	$ 48.95	1
2	Assistant Director of Nursing	1,837	2,126	90,735	42.68	2
3	Registered Nurses	10,338	11,274	347,175	30.79	3
4	Licensed Practical Nurses	32,382	35,388	865,133	24.45	4
5	CNAs & Orderlies	56,903	62,328	692,817	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,332	4,899	85,074	17.37	8
9	Activity Director	1,901	2,078	38,432	18.49	9
10	Activity Assistants	8,293	9,256	96,654	10.44	10
11	Social Service Workers	16,206	17,677	329,706	18.65	11
12	Dietician					12
13	Food Service Supervisor	1,909	2,126	43,211	20.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,091	19,101	206,318	10.80	15
16	Dishwashers					16
17	Maintenance Workers	5,933	6,429	98,703	15.35	17
18	Housekeepers	20,171	22,630	240,324	10.62	18
19	Laundry	6,237	6,874	76,507	11.13	19
20	Administrator	1,837	2,086	122,297	58.63	20
21	Assistant Administrator	3,192	3,513	72,829	20.73	21
22	Other Administrative	693	696	90,651	130.25	22
23	Office Manager					23
24	Clerical	10,732	11,726	296,831	25.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,698	2,003	24,995	12.48	31
32	Other Health Care(specify)					32
33	Other(specify)	7,661	8,353	293,922	35.19	33
34	TOTAL (lines 1 - 33)	211,271	232,665	$ 4,215,210 *	$ 18.12	34

SEE ACCOUNTANTS' PREPARATION 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		$ 8,615	01 - 03	35
36	Medical Director		12,000	09 - 03	36
37	Medical Records Consultant		2,266	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		13,094	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		848	11 - 03	44
45	Social Service Consultant		2,325	12 - 03	45
46	Other(specify)				46
47	See Supplemental				47
48					48
49	TOTAL (lines 35 - 48)		$ 39,148		49

C. CONTRACT NURSES

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

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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	3,640	3,933	44,755	11.38		
MDS / Care Plan Coordinator	10	3,778	4,177	217,438	52.06		
Non-Allowable	43	243	243	31,729	130.57		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		7,661	8,353	293,922	35.19		
Contracted Services							
N/A							
Total						-	-

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Callie Graham	Administrator	0	$ 122,297
Brigitte Anderson	Asst. Admin.	0	32,138
Angela Noland	Asst. Admin.	0	40,691
Sherwin Ray	Administration	0	90,651
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 285,777

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	5,956
Personnel Planners, Inc.	Unemployment Consultant	1,110
Ability Network	Data Processing / IT	6,451
MatrixCare	Data Processing / IT	27,841
Relias Learning	Data Processing / IT	5,311
National Datacare Corporation	Data Processing / IT	4,011
Comcast Cable	Data Processing / IT	1,619
Other	Data Processing / IT	1,617
Terrill Consulting Services	Other Professional	4,800
Other Professional	Other Professional	8,644
Non-Allowable		132,424
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 350,984

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,315
Unemployment Compensation Insurance	54,193
FICA Taxes	320,884
Employee Health Insurance	204,382
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	19,133
TOTAL (agree to Schedule V, line 22, col.8)	$ 684,907

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	21,483
Health Care Worker Background Check	3,056
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	22,569
Licenses and Fees	1,435
Advertising and Promotion	15,019
Alloc. - Extended Care Consulting	987
Less: Public Relations Expense	( )
Non-allowable advertising	(15,019)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,520

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,796
Alloc. - Extended Care Consulting	42
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,838

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $20,479**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 - 10 Yrs**

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

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **453,993**
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.

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(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? **Yes** 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