		FOR BHF USE				

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0050708

Facility Name: Countryside Nrsg Rehab Ctr

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
[ ]	Charitable Corp.	X [ ]	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: Joshua S. Banach Telephone Number: (847) 628-8784
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 1/1/20 to 12/31/20 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)	Denise A Leonard. CPA Partner
	(Firm Name & Address)	Plante & Moran PLLC 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
	(Telephone)	(216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	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	24,655		4,078	28,733	8
9	SNF/PED					9
10	ICF	30,665	793		31,458	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,320	793	4,078	60,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.48%

D. How many bed reserve days during this year were paid by the Department?
None (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 2,713

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr **#** 0050708 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	302,834	45,203	17,569	365,606		365,606	197	365,803			1
2	Food Purchase		361,763		361,763		361,763	144	361,907			2
3	Housekeeping	289,987	63,597	1,924	355,508		355,508	1,720	357,228			3
4	Laundry	41,634	13,620		55,254		55,254		55,254			4
5	Heat and Other Utilities			204,042	204,042		204,042	(14,517)	189,525			5
6	Maintenance	126,126	108,111	3,312	237,549		237,549	20,102	257,651			6
7	Other (specify):*	70,798		47,904	118,702		118,702	5,182	123,884			7
8	**TOTAL General Services**	831,379	592,294	274,751	1,698,424		1,698,424	12,828	1,711,252			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,853,086	266,490	15,271	3,134,847		3,134,847	(3,006)	3,131,841			10
10a	Therapy	51,403		500,202	551,605		551,605		551,605			10a
11	Activities	141,227	2,886	648	144,761		144,761		144,761			11
12	Social Services	366,461	23,459	1,224	391,144		391,144		391,144			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,412,177	292,835	547,345	4,252,357		4,252,357	(3,006)	4,249,351			16
	C. General Administration											
17	Administrative	329,796			329,796		329,796	24,630	354,426			17
18	Directors Fees											18
19	Professional Services			571,886	571,886		571,886	(197,210)	374,676			19
20	Dues, Fees, Subscriptions & Promotions			67,469	67,469		67,469	(12,139)	55,330			20
21	Clerical & General Office Expenses	220,607	183,931	67,928	472,466		472,466	15,966	488,432			21
22	Employee Benefits & Payroll Taxes			665,058	665,058		665,058		665,058			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,377	4,377		4,377	523	4,900			24
25	Other Admin. Staff Transportation			7,115	7,115		7,115	986	8,101			25
26	Insurance-Prop.Liab.Malpractice			382,374	382,374		382,374	2,113	384,487			26
27	Other (specify):*							36,249	36,249			27
28	**TOTAL General Administration**	550,403	183,931	1,766,207	2,500,541		2,500,541	(128,882)	2,371,659			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,793,959	1,069,060	2,588,303	8,451,322		8,451,322	(119,060)	8,332,262			29

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

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			43,037	43,037		43,037	46,863	89,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							437,228	437,228			32
33	Real Estate Taxes			803,434	803,434		803,434	6,597	810,031			33
34	Rent-Facility & Grounds			782,738	782,738		782,738	(780,000)	2,738			34
35	Rent-Equipment & Vehicles			11,846	11,846		11,846	360	12,206			35
36	Other (specify):*			699	699		699	(699)				36
37	TOTAL Ownership			1,641,754	1,641,754		1,641,754	(289,651)	1,352,103			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,459	51,935	55,394		55,394	(3,910)	51,484			39
40	Barber and Beauty Shops			140	140		140	(140)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			468,837	468,837		468,837		468,837			42
43	Other (specify):*	88,351		33,997	122,348		122,348	(122,348)				43
44	TOTAL Special Cost Centers	88,351	3,459	554,909	646,719		646,719	(126,398)	520,321			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,882,310	1,072,519	4,784,966	10,739,795		10,739,795	(535,109)	10,204,686			45

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(16,400)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,523)	30		9
10	Interest and Other Investment Income	(33,095)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(699)	36		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	(32,744)	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				24
25	Fund Raising, Advertising and Promotional	(122,349)	43		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	(225,189)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (450,999)		$	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)	(84,111)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (84,111)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (535,110)		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

Countryside Nrsg Rehab Ctr

ID# 0050708

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Countryside HC, LLC Management Fees	$ (9,850)	17	1
2	Countryside HC, LLC Filing Fees	(75)	21	2
3	Countryside HC, LLC Amortization	(4,634)	31	3
4	Countryside HC, LLC Replacement Taxes	(8,750)	21	4
5	PAC Dues	(15,346)	20	5
6	Patient Clothing	(653)	10	6
7	Barber & Beauty Expense	(140)	40	7
8	Bank Charges	(7,606)	21	8
9	Theft & Damage Loss	(5,193)	21	9
10	Collections Expense	(367)	21	10
11	Replacement Taxes	(666)	21	11
12	Capitalized R&M	(12,062)	06	12
13	Non-Allowable Legal	(31,372)	19	13
14	Non-Allowable Expense	(128,475)	21	14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(225,189)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	197	0	0	0	0	0	0	0	0	197	1
2	Food Purchase	0	0	144	0	0	0	0	0	0	0	0	144	2
3	Housekeeping	0	0	1,720	0	0	0	0	0	0	0	0	1,720	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,883	0	0	0	0	0	0	0	0	1,883	5
6	Maintenance	(12,062)	0	3,752	28,412	0	0	0	0	0	0	0	20,102	6
7	Other (specify):*	0	0	0	5,182	0	0	0	0	0	0	0	5,182	7
8	**TOTAL General Services**	(12,062)	0	7,695	33,594	0	0	0	0	0	0	0	29,228	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	(653)	0	0	0	0	(2,353)	0	0	0	0	0	(3,006)	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**	(653)	0	0	0	0	(2,353)	0	0	0	0	0	(3,006)	16
	C. General Administration													
17	Administrative	(9,850)	9,850	0	24,630	0	0	0	0	0	0	0	24,630	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(31,372)	0	(165,838)	0	0	0	0	0	0	0	0	(197,210)	19
20	Fees, Subscriptions & Promotions	(15,346)	0	3,207	0	0	0	0	0	0	0	0	(12,139)	20
21	Clerical & General Office Expenses	(151,132)	8,825	16,886	174,131	0	0	0	0	0	0	0	48,710	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	523	0	0	0	0	0	0	0	0	523	24
25	Other Admin. Staff Transportation	0	0	986	0	0	0	0	0	0	0	0	986	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,113	0	0	0	0	0	0	0	0	2,113	26
27	Other (specify):*	0	0	0	36,249	0	0	0	0	0	0	0	36,249	27
28	**TOTAL General Administration**	(207,700)	18,675	(142,122)	235,009	0	0	0	0	0	0	0	(96,138)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(220,415)	18,675	(134,427)	268,604	0	(2,353)	0	0	0	0	0	(69,916)	29

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	(20,523)	64,070	3,316	0	0	0	0	0	0	0	0	46,863	30
31	Amortization of Pre-Op. & Org.	(4,634)	4,634	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	458,471	11,852	0	0	0	0	0	0	0	0	470,323	32
33	Real Estate Taxes	0	0	6,597	0	0	0	0	0	0	0	0	6,597	33
34	Rent-Facility & Grounds	0	(810,000)	0	0	0	0	0	0	0	0	0	(810,000)	34
35	Rent-Equipment & Vehicles	0	0	360	0	0	0	0	0	0	0	0	360	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,157)	(282,825)	22,125	0	0	0	0	0	0	0	0	(285,857)	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	(3,910)	0	0	0	0	0	(3,910)	39
40	Barber and Beauty Shops	(140)	0	0	0	0	0	0	0	0	0	0	(140)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(140)	0	0	0	0	(3,910)	0	0	0	0	0	(4,050)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(245,712)	(264,150)	(112,302)	268,604	0	(6,263)	0	0	0	0	0	(359,824)	45

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 810,000	Countryside Healthcare Center, LLC	100.00%	$	$ (810,000)	1
2	V	33	Real Estate Taxes	773,434	Countryside Healthcare Center, LLC	100.00%	773,434		2
3	V	17	Management Fees		Countryside Healthcare Center, LLC	100.00%	9,850	9,850	3
4	V	21	Filing Fees		Countryside Healthcare Center, LLC	100.00%	75	75	4
5	V	30	Depreciation Expense		Countryside Healthcare Center, LLC	100.00%	64,070	64,070	5
6	V	31	Amortization Expense		Countryside Healthcare Center, LLC	100.00%	4,634	4,634	6
7	V	32	Interest Expense		Countryside Healthcare Center, LLC	100.00%	458,471	458,471	7
8	V	21	Replacement Taxes		Countryside Healthcare Center, LLC	100.00%	8,750	8,750	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,583,434			$ 1,319,284	$ * (264,150)	14

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

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 REHABIL	BEECHER	EXTENDED CARE C(	EVANSTON	MGMT/BOOKKEE	1
2	Rothner Family Grandchildren Trust	10.00%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CI	EVANSTON	CLINICAL	2
3	N & S Rothner Family Trust	88.00%	CHATEAU NURSING AND REHABILITATIOI	WILLOWBROOK	CARE CENTERS BUI	EVANSTON	BUILDING COMPA	3
4			WESTMONT MANOR HEALTH & REHAB CE	WESTMONT	VENT LEASE LLC	EVANSTON	NURSING EQUIPM	4
5			GRASMERE PLACE, LLC	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURAI	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	MAC RX	DES PLAINES	PHARMACY	6
7			LAKEWOOD NURSING & REHABILITATION	PLAINFIELD	Countryside	Dolton, IL	Bldg. Company	7
8			LEMONT NURSING AND REHABILITATION	LEMONT	HC Center, LLC			8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH (	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITA'	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER,	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REH.	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CEN'	HOMEWOOD				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			TIMBER POINT HEALTHCARE CENTER, IN(	CAMP POINT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 197	$ 197	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	144	144	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,720	1,720	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,883	1,883	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,752	3,752	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	0		20
21	V	19	Professional Fees		Extended Care Consulting, LLC	100.00%	7,668	7,668	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,207	3,207	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,886	16,886	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	523	523	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	986	986	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,113	2,113	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,316	3,316	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,852	11,852	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	6,597	6,597	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	0		30
31	V	35	Rent - Equipment		Extended Care Consulting, LLC	100.00%	360	360	31
32	V								32
33	V								33
34	V	19	Consulting Fees	173,506				(173,506)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 173,506			$ 61,204	$ * (112,302)	39

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salaries	$	Extended Care Consulting, LLC	100.00%	$ 28,412	$ 28,412	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC	100.00%	5,182	5,182	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative Salaries		Extended Care Consulting, LLC	100.00%	24,630	24,630	21
22	V	21	Office and Clerical Salaries		Extended Care Consulting, LLC	100.00%	174,131	174,131	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC	100.00%	36,249	36,249	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			$			$ 268,603	$ * 268,604	39

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$ 254,743	CCS VEBA	100.00%	$ 254,743	$	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			$ 254,743			$ 254,743	$ *	39

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$ 25,178	Mac Rx LLC	100.00%	$ 22,825	$ (2,353)	15
16	V	39	Ancillary	41,832	Mac Rx LLC	100.00%	37,922	(3,910)	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			$ 67,010			$ 60,747	$ * (6,263)	39

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Adam Vales	Relative	Clerical	0.00	See Supplemental	1.27	3.18%	Alloc. Salary	$ 2,264	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	$ 2,264		13

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

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
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	01	Dietary	Resdient Days	1,219,947	36	$ 3,992	$	60,191	$ 197	1
2	02	Food	Resdient Days	1,219,947	36	2,910		60,191	144	2
3	03	Housekeeping	Resdient Days	1,219,947	36	34,856		60,191	1,720	3
4	05	Utilities	Resdient Days	1,219,947	36	38,173		60,191	1,883	4
5	06	Maintenance	Resdient Days	1,219,947	36	76,040		60,191	3,752	5
6	17	Administrative	Resdient Days	1,219,947	36			60,191		6
7	19	Professional Fees	Resdient Days	1,219,947	36	155,408		60,191	7,668	7
8	20	Dues and Subscriptions	Resdient Days	1,219,947	36	64,998		60,191	3,207	8
9	21	Office and Clerical	Resdient Days	1,219,947	36	342,251		60,191	16,886	9
10	24	Seminar and Travel	Resdient Days	1,219,947	36	10,602		60,191	523	10
11	25	Other Staff Admin. Trans.	Resdient Days	1,219,947	36	19,988		60,191	986	11
12	26	Insurance	Resdient Days	1,219,947	36	42,836		60,191	2,113	12
13	30	Depreciation	Resdient Days	1,219,947	36	67,209		60,191	3,316	13
14	32	Interest	Resdient Days	1,219,947	36	240,208		60,191	11,852	14
15	33	Real Estate Taxes	Resdient Days	1,219,947	36	133,701		60,191	6,597	15
16	34	Rent - Building	Resdient Days	1,219,947	36			60,191		16
17	35	Rent - Equipment	Resdient Days	1,219,947	36	7,304		60,191	360	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,240,476	$		$ 61,204	25

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
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	06	Maintenance Salaries	Resident Days	1,219,947	36	$ 575,856	$ 575,856	60,191	$ 28,412	1
2	06	Maintenance (Direct)								2
3	07	Emp. Ben. - Gen. Serv.	Resident Days	1,219,947	36	105,021		60,191	5,182	3
4	07	Emp. Ben. - Gen. Serv. (Direct)								4
5	12	Admission (Direct)								5
6	15	Emp. Ben. - Nursing (Direct)								6
7	17	Administrative Salaries	Resident Days	1,219,947	36	499,202	499,202	60,191	24,630	7
8	21	Office and Clerical Salaries	Resident Days	1,219,947	36	3,529,267	3,529,267	60,191	174,131	8
9	21	Office and Clerical (Direct)								9
10	27	Emp. Ben. - Gen. Admin.	Resident Days	1,219,947	36	734,685		60,191	36,249	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					$ 5,444,030	$ 4,604,325		$ 268,604	25

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	8,032,049		$ 8,032,049	$	254,743	$ 254,743	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,032,049	$		$ 254,743	25

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 220-2700
Fax Number: (224) 220-2730

	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	Profit Margin	690,072	26	$ 625,580	$	25,178	$ 22,825	1
2	39	Ancillary	Profit Margin	4,277,990	26	3,878,179		41,832	37,922	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					$ 4,503,759	$		$ 60,747	25

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Inland Bank		X	Mortgage			$	$ 9,559,521			$ 458,471	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	Allocated From ECC		X								11,852	7
8												8
9	TOTAL Facility Related						$	$ 9,559,521			$ 470,323	9
	B. Non-Facility Related*											
10	Interest Income		X								(33,095)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,095)	14
15	TOTALS (line 9+line14)						$	$ 9,559,521			$ 437,228	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	417,207	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.)	$	775,789	2
3. Under or (over) accrual (line 2 minus line 1).	$	358,582	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	384,606	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.)**	$	66,843	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.	$	810,031	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	642,378	8
2016	665,050	9
2017	794,859	10
2018	765,190	11
2019	769,211	12

Beginning Accrual Adjusted to Account for Assessment Reduction
Allocated From ECC: $6,597

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Joshua S. Banach

TELEPHONE (847) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-13-100-001-0000	Long Term Care Property	$ 769,211.42	$ 769,211.42
2.	Allocated From ECC	Home Office Allocation	$ 197,163.00	$ 6,597.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 966,374.42	$ 775,808.42

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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).
None

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	Allocated From ECC			27,436	2
3	TOTALS			$ 420,186	3

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	197			1977	$ 5,408,525	$	40	$	$	$ 5,408,525	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1991	24,648		20			24,648	9
10	Various			1992	28,172		20			28,172	10
11	Various			1993	11,940		20			11,940	11
12	Various			1994	4,878		20			4,878	12
13	Various			1995	34,004		20			34,004	13
14	Various			1996	20,232		20			20,232	14
15	Various			1997	17,236		20			17,236	15
16	Various			1998	13,979		20			13,979	16
17	Various			1999	33,838		20			33,838	17
18	Various			2000	18,955		20			18,955	18
19	Various			2001	8,806		20	440	440	8,806	19
20	Various			2003	136,685		20	6,834	6,834	123,017	20
21	Various			2004	49,614		20	2,481	2,481	42,172	21
22	Various			2005	80,983		20	4,049	4,049	64,786	22
23	Various			2006	65,138		20	3,257	3,257	48,854	23
24	Various			2007	46,168		20	2,308	2,308	32,318	24
25	Various			2008	74,086		20	3,704	3,704	48,156	25
26	Various			2010	8,569		20	428	428	4,713	26
27	Various			2011	21,657		20	1,083	1,083	10,829	27
28	Various			2012	73,903		20	3,695	3,695	33,256	28
29	Various			2013	108,753		20	5,438	5,438	43,501	29
30	Various			2014	33,073		20	1,654	1,654	11,576	30
31	Drywall, Handrail, and Wallguards Installation			2015	8,915		20	446	446	2,675	31
32	Flooring - Resident Rooms			2016	22,796		20	1,140	1,140	5,699	32
33	Illuminated Sign - Exterior			2016	5,200		20	260	260	1,300	33
34	Roof Repairs			2016	3,725		20	186	186	931	34
35	Parking Lot - Pave and Seal			2016	34,377		20	1,719	1,719	8,594	35
36	Doors - Dining Room			2016	3,643		20	182	182	911	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			$	$		$	$	$	37
38	Electrical Panel - Wire Transfer	2016	9,500		20	475	475	2,375	38
39	Call Light System - Resident Rooms	2016	10,925		20	546	546	2,731	39
40	Electrical Panel - Install 2 New Ampere 120 Volt Circuts	2017	10,200		20	510	510	2,040	40
41	Painting - Spot Areas	2017	2,860		20	143	143	572	41
42	Air Conditioner - Install - Rooftop	2018	7,690		20	385	385	1,154	42
43	Bathroom Remodeling - 4 - Demo, Drywall, Mix Values, Toilets, Sin	2018	33,946		20	1,697	1,697	5,092	43
44	Cooling System - Dietary	2018	11,900		20	595	595	1,785	44
45	Facility Remodeling								45
46	Vestible - Demo, Carpet Tile and Millwork Base	2018	1,375		20	69	69	206	46
47	Lobby - Demo, Flooring, Millwork Base, Wallcovering, Wall, Lights,								47
48	Sheers, Doors	2018	13,120		20	656	656	1,968	48
49	Administrative & Conference Room - Demo, Cove Base, Carpet	2018	3,671		20	184	184	551	49
50	Admissions and Asst. Admin. - Demo, Cove Base, Tile, and Light	2018	3,160		20	158	158	474	50
51	Lobby and Vestibule - Electric, Wallcovering, and Paint	2018	8,652		20	433	433	1,298	51
52	Offices - Paint and Lighting Installation	2018	7,079		20	354	354	1,062	52
53	Project Management Fee	2018	2,700		20	135	135	405	53
54	Interior Remodeling Project - Exterior work, Confrence Room Floo	2018	8,057		20	403	403	1,209	54
55	Replace River Rock Wall; Install flooring	2019	4,800		20	240	240	480	55
56	Metal Door with Frame for Main Office Electrical Closet	2019	2,756		20	138	138	276	56
57	Replace Panic Bar on Front Entrance Door	2019	3,863		20	193	193	386	57
58	Repairs to Air/Furnace Systems-Maint Office/Kitchen/Rooms	2019	5,968		20	298	298	597	58
59	Replacement of Water Heater Vent 27-3 4IN	2019	5,938		20	297	297	594	59
60	Underground Power Supply For Sign in Front of Building	2019	8,504		20	425	425	850	60
61	Repair to Central AC-Condensor Motor- Maint Office/C Wing	2019	3,085		20	154	154	309	61
62	Repair to AC- Therapy/Res Rms-Overload Current/Condensor	2019	2,665		20	133	133	267	62
63	Install Suveillance System- Cabling and Cameras	2019	2,816		20	141	141	282	63
64	Flat Roof Repair- Shingles, Sealant to Stop Leaks	2020	3,663		20	183	183	183	64
65	Electrical Wiring and Lighting Upgrade- Outdoor Smoking Area	2020	3,900		20	195	195	195	65
66	Countryside Healthcare Center, LLC - Various	2001	256,048		20	12,802	12,802	256,048	66
67									67
68	Financial Statement Depreciation- Countryside Nursing & Rehab Center			43,037			(43,037)		68
69	Financial Statement Depreciation- Countryside HC Center LLC			64,070			(64,070)		69
70	TOTAL (lines 4 thru 69)		$ 6,841,339	$ 107,107		$ 61,247	$ (45,861)	$ 6,391,886	70

**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: 1/1/20 Ending: 12/31/20

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		$ 6,841,339	$ 107,107		$ 61,247	$ (45,860)	$ 6,391,886	1
2	Related Party Allocations								2
3									3
4	Dyer Building Allocation	2007	11,841	262	40	262		3,541	4
5	Allocated From ECC/2201 Main	2002	37,808	969	40	969		17,732	5
6									6
7	Allocated From ECC/2201 Main	2002	31,232		20			31,232	7
8	Allocated From ECC/2201 Main	2003	36,806		20			36,806	8
9	Allocated From ECC/2201 Main	2005	1,829		20			1,829	9
10	Allocated From ECC/2201 Main	2009	330	16	20	16		198	10
11	Allocated From ECC/2201 Main	2014	3,167	158	20	158		1,108	11
12	Allocated From ECC/2201 Main	2015	520	26	20	26		337	12
13	Allocated From ECC/2201 Main	2016	2,055	103	20	103		514	13
14	Allocated From ECC/2201 Main	2017	3,565	178	20	178		713	14
15	Allocated From ECC/2201 Main	2018	1,634	82	20	82		245	15
16	Allocated From ECC/2201 Main	2019	615	31	20	31		62	16
17	Allocated From ECC/2201 Main	2020	165	8	20	8		8	17
18									18
19	Allocated From ECC	2007	227	11	20	11		159	19
20	Allocated From ECC	2009	136	7	20	7		82	20
21	Allocated From ECC	2010	1,331	67	20	67		732	21
22	Allocated From ECC	2011	479	24	20	24		240	22
23	Allocated From ECC	2012	158	8	20	8		71	23
24	Allocated From ECC	2014	2,188	109	20	109		766	24
25	Allocated From ECC	2016	2,624	131	20	131		656	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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 12D, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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 12E, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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 12F, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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 12G, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,980,049	$ 109,297		$ 63,437	$ (45,860)	$ 6,488,917	34

**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: 1/1/20 Ending: 12/31/20

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	$ 248,878	$	$ 24,888	$ 24,888	10	$ 124,439	71
72	Current Year Purchases	4,499		450	450	10	450	72
73	Fully Depreciated Assets					10		73
74	See Attached	555,564	1,125	1,125			554,867	74
75	TOTALS	$ 808,941	$ 1,125	$ 26,463	$ 25,338		$ 679,756	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	Allocated From ECC		2014	$ 1,256	$	$	$		$ 1,256	76
77										77
78										78
79										79
80	TOTALS			$ 1,256	$	$	$		$ 1,256	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)	$ 8,210,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,422	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 89,899	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,523)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,169,929	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.

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								5
6	Storage Unit				2,738			6
7	TOTAL				$ 2,738 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 3,112 Description: $408 Water Cooler; $2,344 Copier/Printer/Postage Machine; $360 Allocated From ECC
    (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	$ 757.88	$ 9,095	17
18					18
19					19
20					20
21	TOTAL		$ 757.88	$ 9,095	21

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

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	hrs	$	3,182	$ 238,647	$	3,182	$ 238,647	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		474	35,515		474	35,515	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		3,014	226,040		3,014	226,040	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	51,403					51,403	8
9	Pharmacy	V39	# of prescrpts				44,454		44,454	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					7,428		7,428	12
13	Other (specify): BILLABLE SUPPLIES	V39					3,459		3,459	13
14	TOTAL			$ 51,403	6,669	$ 500,202	$ 55,341	6,669	$ 606,946	14

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 1,417,142	$ 1,461,509	1
2	Cash-Patient Deposits	1,275,559	1,275,559	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,369,749	1,369,749	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	152,979	152,979	6
7	Other Prepaid Expenses	829	829	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	54,870	58,945	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,271,128	$ 4,319,570	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	5,955,273	5,955,273	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	477,977	734,025	15
16	Equipment, at Historical Cost	241,828	635,828	16
17	Accumulated Depreciation (book methods)	(350,110)	(5,278,028)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		532,463	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(506,566)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	512,929	3,758,624	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,837,897	$ 11,632,894	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,109,025	$ 15,952,464	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,552,975	$ 1,552,971	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	129,802	129,802	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	524,538	524,538	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,804	25,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)		384,606	32
33	Accrued Interest Payable		13,116	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	473,140	473,140	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,706,259	$ 3,103,977	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,559,521	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,136,236	1,136,236	43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,136,236	$ 10,695,757	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,842,495	$ 13,799,734	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,266,530	$ 2,152,730	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,109,025	$ 15,952,464	48

*(See instructions.)

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,358,356	1
2	Restatements (describe):		2
3	Prior Year Accrued Expense Adjustment	(29)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,358,327	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,801,682	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	(893,479)	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)**	$ 3,908,203	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)**	$ 7,266,530	24 *

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 13,225,284	1
2	Discounts and Allowances for all Levels	(1,603,803)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,621,481	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,396,973	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,396,973	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	45,265	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,957	19
20	Radiology and X-Ray	1,050	20
21	Other Medical Services	983	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 57,255	23
	D. Non-Operating Revenue		
24	Contributions	100	24
25	Interest and Other Investment Income***	33,095	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,195	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a		2,432,573	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,432,573	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,541,477	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,698,424	31
32	Health Care	4,252,357	32
33	General Administration	2,500,541	33
	B. Capital Expense		
34	Ownership	1,641,754	34
	C. Ancillary Expense		
35	Special Cost Centers	177,882	35
36	Provider Participation Fee	468,837	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,739,795	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,801,682	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,801,682	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,627,035	44
45	Private Pay - Net Inpatient Revenue	191,685	45
46	Medicare - Net Inpatient Revenue	945,079	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	224,475	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(366,793)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,621,481	49

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

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

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

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

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,595	1,771	$ 85,662	$ 48.37	1
2	Assistant Director of Nursing	1,644	1,704	75,479	44.30	2
3	Registered Nurses	18,264	20,589	768,125	37.31	3
4	Licensed Practical Nurses	33,332	36,415	1,088,560	29.89	4
5	CNAs & Orderlies	49,622	54,917	810,164	14.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,936	3,340	51,403	15.39	8
9	Activity Director	1,827	1,952	32,836	16.82	9
10	Activity Assistants	7,593	8,750	108,391	12.39	10
11	Social Service Workers	15,258	16,395	366,461	22.35	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,085	46,267	22.19	13
14	Head Cook	16,406	19,165	256,567	13.39	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,881	7,626	126,126	16.54	17
18	Housekeepers	21,471	24,075	289,987	12.05	18
19	Laundry	2,637	3,057	41,634	13.62	19
20	Administrator	3,290	3,554	242,671	68.28	20
21	Assistant Administrator	2,876	3,180	87,126	27.40	21
22	Other Administrative	7,993	9,097	220,607	24.25	22
23	Office Manager					23
24	Clerical					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	1,526	1,703	25,097	14.74	31
32	Other Health Care(specify)	4,507	5,142	70,798	13.77	32
33	Other(specify)	2,029	2,217	88,351	39.85	33
34	TOTAL (lines 1 - 33)	203,555	226,734	$ 4,882,312 *	$ 21.53	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 17,569	V01-03	35
36	Medical Director	Monthly Fees	30,000	V09-03	36
37	Medical Records Consultant	24	2,285	V10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	12,986	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	648	V11-03	44
45	Social Service Consultant	24	1,224	V12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	$ 64,712		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aasta James	Administrator	0.00%	$ 123,160
Brigitte Anderson	Asst Admin	0.00%	51,867
Sherwin Ray	Administrative	0.00%	79,769
Jacob Bakst	Administrative	0.00%	75,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 329,796

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
Ability Networks	Data Processing/Billing	$ 11,309
Matrix Care	Data Processing/Software	32,117
National Data Care Corp	Resident Fund Management	4,358
Paycor	Payroll Processing	26,842
See Attached	Legal Services	128,996
Plante Moran	Accounting Services	17,000
Extended Care Consulting	Consulting/Bookkeeping	173,506
Personnel Planners	Unemployment Consulting	660
RLC	Consulting Services	3,120
Finkel, Martwick, & Colson	Real Estate Tax Appeal	66,824
IIT/Sourcetech	IT Consulting	660
See Supplemental Page 21		106,494
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 571,886

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,863
Unemployment Compensation Insurance	33,285
FICA Taxes	348,971
Employee Health Insurance	145,477
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Dues	3,031
Other Employee Welfare	15,245
Holiday Expenses	5,186
TOTAL (agree to Schedule V, line 22, col.8)	$ 665,058

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	24,315
Health Care Worker Background Check	4,228
(Indicate # of checks performed 423)	
Patient Background Checks	
Dues & Subscriptions	16,944
Licenses & Fees	4,646
Allocated From ECC	3,207
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,330

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,377
Allocated From ECC	523
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,900

**See instructions.

Facility Name & ID Number Countryside Nrsg Rehab Ctr # 0050708 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

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
Mid Cap	LOC Consulting	$ 6,068
Sherwin Ray	Consulting Fees	40,463
Terrill Consulting Services	AR Consulting Services	59,963
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 106,494

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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? **No**
If YES, give association name and amount. **Healthcare Council IL $30,693**

(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 **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **468,837**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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 out of Schedule V? **Yes**

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