

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 3000437

Facility Name: Countryside Care Center

Address: 400 West Grant St Macomb 61455
Number City Zip Code

County: McDonough

Telephone Number: (309) 837-2386 Fax # (309) 836-9191

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2024

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
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 1/1/2025 to 12/31/2025 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Care Center # 3000437 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>16</u>	Skilled (SNF)	<u>16</u>	<u>5,840</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>46</u>	Intermediate (ICF)	<u>46</u>	<u>16,790</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>62</u>	TOTALS	<u>62</u>	<u>22,630</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,097	201	1,298	8
9	SNF/PED									9
10	ICF	1,844	11,822	1,402		96			15,164	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,844	11,822	1,402		96	1,097	201	16,462	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 72.74%

SEE ACCOUNTANTS' PREPARATION REPORT

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) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 11/1/24

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 12/1/24 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 16

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

Facility Name & ID Number Countryside Care Center # 3000437 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	218,214	9,481	5,857	233,552		233,552		233,552			1
2	Food Purchase		109,764		109,764		109,764		109,764			2
3	Housekeeping	85,491	4,353		89,844		89,844		89,844			3
4	Laundry	69,947	3,561		73,508		73,508		73,508			4
5	Heat and Other Utilities			58,520	58,520		58,520	465	58,985			5
6	Maintenance	31,665	23,321	62,455	117,441		117,441	(35,988)	81,453			6
7	Other (specify):* Waste Disposal			6,565	6,565		6,565		6,565			7
8	TOTAL General Services	405,317	150,480	133,397	689,194		689,194	(35,523)	653,671			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	1,363,201	100,287	109,633	1,573,121		1,573,121	45,234	1,618,355			10
10a	Therapy											10a
11	Activities	80,380	5,138		85,518		85,518		85,518			11
12	Social Services	40,314			40,314		40,314		40,314			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Home Office Benefit							6,914	6,914			15
16	TOTAL Health Care and Programs	1,483,895	105,425	117,633	1,706,953		1,706,953	52,148	1,759,101			16
	C. General Administration											
17	Administrative	96,476		221,700	318,176		318,176	(216,332)	101,844			17
18	Directors Fees											18
19	Professional Services			35,214	35,214		35,214	47,160	82,374			19
20	Dues, Fees, Subscriptions & Promotions			30,109	30,109		30,109	2,818	32,927			20
21	Clerical & General Office Expenses		5,231	5,190	10,421		10,421	82,507	92,928			21
22	Employee Benefits & Payroll Taxes			307,280	307,280		307,280		307,280			22
23	Inservice Training & Education											23
24	Travel and Seminar			680	680		680	3,134	3,814			24
25	Other Admin. Staff Transportation			481	481		481	9,161	9,642			25
26	Insurance-Prop.Liab.Malpractice			81,033	81,033		81,033	1,189	82,222			26
27	Other (specify):* Allocated Home Office Benefit							11,415	11,415			27
28	TOTAL General Administration	96,476	5,231	681,687	783,394		783,394	(58,948)	724,446			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,985,688	261,136	932,717	3,179,541		3,179,541	(42,323)	3,137,218			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							15,237	15,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,500	12,500		12,500	(11,678)	822			32
33	Real Estate Taxes			22,867	22,867		22,867	(18,076)	4,791			33
34	Rent-Facility & Grounds			237,500	237,500		237,500	(13,334)	224,166			34
35	Rent-Equipment & Vehicles			3,326	3,326		3,326		3,326			35
36	Other (specify):* Loan Costs			7,500	7,500		7,500		7,500			36
37	TOTAL Ownership			283,693	283,693		283,693	(27,851)	255,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	86,002	62,759	53,595	202,356		202,356	77,269	279,625			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,823	218,823		218,823		218,823			42
43	Other (specify):* Disallowed Costs			53,974	53,974		53,974	(53,974)				43
44	TOTAL Special Cost Centers	86,002	62,759	326,392	475,153		475,153	23,295	498,448			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,071,690	323,895	1,542,802	3,938,387		3,938,387	(46,879)	3,891,508			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

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	(6,334)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,237	30		9
10	Interest and Other Investment Income	(17,615)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,005)	43		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	(39,847)	43		24
25	Fund Raising, Advertising and Promotional	(2,788)	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 See Page 5A	(316,391)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (372,743)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	325,864		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 325,864		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (46,879)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Non-Allowable Travel	(194)	25	3
4	Disallow Related Party Interest Expense	(207,385)	32	4
5	Capitalize Equipment/Repairs over \$2,500	(36,670)	6	5
6	Capitalize Equipment over \$2,500	(27,661)	10	6
7	Capitalize Large Allocated Repair-Home Office	(465)	6	7
8	Disallow Non Allowable Allocated Home Office Exp	(6,150)	21	8
9	Disallow Non Allowable Allocated Home Office Exp	(1,648)	25	9
10	Disallow Owner Wages	(33,448)	17	10
11	Disallow Owner Wages	(2,770)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(316,391)		49

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 Ownership Listing-1		See Page 6-Supp		See Page 6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ 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	32	Interest	\$ 12,500	400 Grant Street LLC		\$ 225,000	\$ 212,500	1
2	V	33	Real Estate Taxes	19,055	400 Grant Street LLC			(19,055)	2
3	V	34	Rent	17,500	400 Grant Street LLC		4,166	(13,334)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 49,055			\$ 229,166	\$ * 180,111	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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. ☒ 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	5	Heat and Other Utilities	\$	Stern Therapy Consultants, LLC		\$ 465	\$ 465	15
16	V	6	Maintenance		Stern Therapy Consultants, LLC		1,147	1,147	16
17	V	19	Professional Services		Stern Therapy Consultants, LLC		47,160	47,160	17
18	V	20	Dues, Fees, Subscriptions & Promotions		Stern Therapy Consultants, LLC		2,817	2,817	18
19	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		9,885	9,885	19
20	V	24	Travel and Seminar		Stern Therapy Consultants, LLC		3,134	3,134	20
21	V	25	Other Admin. Staff Transportation		Stern Therapy Consultants, LLC		11,003	11,003	21
22	V	26	Insurance-Prop.Liab.Malpractice		Stern Therapy Consultants, LLC		1,189	1,189	22
23	V	33	Real Estate Taxes		Stern Therapy Consultants, LLC		979	979	23
24	V	34	Rent-Facility & Grounds		Stern Therapy Consultants, LLC		2,348	2,348	24
25	V								25
26	V								26
27	V	10	Nursing and Medical Records		Stern Therapy Consultants, LLC		72,895	72,895	27
28	V	15	Emp. Ben.-Nsg & Med		Stern Therapy Consultants, LLC		6,914	6,914	28
29	V	17	Administrative	221,700	Stern Therapy Consultants, LLC		33,448	(188,252)	29
30	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		70,829	70,829	30
31	V	27	Emp. Ben.-Gen. Admin.		Stern Therapy Consultants, LLC		9,890	9,890	31
32	V	39	Therapy Wages		Stern Therapy Consultants, LLC		73,305	73,305	32
33	V	39	Emp. Ben.-Therapy		Stern Therapy Consultants, LLC		6,953	6,953	33
34	V								34
35	V	17	Administrative		Stern Therapy Consultants, LLC		5,368	5,368	35
36	V	21	Clerical & General Office Expenses		Stern Therapy Consultants, LLC		10,713	10,713	36
37	V	27	Emp. Ben.-Gen. Admin.		Stern Therapy Consultants, LLC		1,525	1,525	37
38	V								38
39	Total			\$ 221,700			\$ 371,967	\$ * 150,267	39

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.

☒ 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	20	Dues, Fees, Subscriptions & Promotions	\$	CET Office Holdings, LLC		\$ 1	\$ 1	15
16	V	32	Interest Expense		CET Office Holdings, LLC		822	822	16
17	V	34	Rent	2,348	CET Office Holdings, LLC			(2,348)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,348			\$ 823	\$ * (1,525)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.

☒ 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	39	Pharmacy	\$ 62,759	Medwiz of Illinois, LLC		\$ 59,770	\$ (2,989)	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			\$ 62,759			\$ 59,770	\$ * (2,989)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS				Ownership Listing-1					
Countryside Care Center									
ID#		3000437							
Report Period Beginning:		1/1/2025		Stern Therapy Consult					
Ending:		12/31/2025		400 Grant Street LLC					
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management					
-Owners of companies must be listed instead of company names.				Operator/Licensee		Building Co.		Co./Home Office	
-Names of trust beneficiaries must be listed.				Place of Residence		Ownership Percentage		Ownership Percentage	
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage	
1	Eric	NG	Newhouse as Trustee*	Suffern	NY	11.86750	16.66500	22.72500	1
2	Femi	NG	Newhouse as Trustee*	Suffern	NY	11.63250	16.33500	22.27500	2
3	Boruch	NG	Sheps	Spring Valley	NY	10.00000	10.00000		3
4	Benjamin	NG	Friedman	Pomona	NY	15.00000	7.50000		4
5	Bezalel	NG	Stern	Monsey	NY	4.50000	10.00000	55.00000	5
6	Avraham	NG	Erblich	Pomona	NY	16.00000	2.50000		6
7	Chaim	O	Millman as Trustee**	Pomona	NV	11.86750	12.62500		7
8	Lisa	NG	Millman as Trustee**	Pomona	NV	11.63250	12.37500		8
9	Dina	NG	Hirsch	Pomona	NY	2.00000	2.00000		9
10	Daniella	NG	Unger	Pomona	NY	1.50000	1.50000		10
11	Shmuel	NG	Cohn	Clifton	NJ	0.99990	0.99990		11
12	Sara	NG	Cohn	Clifton	NJ	2.00010	2.00010		12
13	Aharon	NG	Wolf	Pomona	NY	1.00000	1.00000		13
14	Avraham	NG	Sackton				4.50000		14
15									15
16									16
17									17
18									18
19									19
20	*Trustee in ETN Family Holdings								20
21	**Trustee in TLCO Holdings								21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
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37									37
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

Facility Name & ID Number

Countryside Care Center

3000437

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Carmi Manor Rehab & Nursing Center	Carmi, IL	Stern Therapy	Pomona, NY	Back Office and	1
2			Casey Rehab and Nursing	Casey, IL	Consultants, LLC		Therapy Mgmt	2
3			Gallatin Manor	Ridgway, IL	400 Grant Street LLC	Pomona, NY	Property Co.	3
4			Henry Rehab and Nursing	Henry, IL	CET Office Holdings I	Pomona, NY	Stern Building	4
5			Lacon Rehab and Nursing	Lacon, IL	HCIT LLC	Bardonia, NY	IT Consulting	5
6			Macomb Post Acute Care Center	Macomb, IL	Medwiz of Illinois, LL	Bardonia, NY	Pharmacy	6
7			Marshall Rehabilitation and Nursing	Marshall, IL	CBE Funding, LLC	Pomona, NY	Finance Company	7
8			Mascoutah Rehab and Nursing	Mascoutah, IL				8
9			Mercer Manor Rehabilitation	Aledo, IL				9
10			Monmouth Rehab and Nursing	Monmouth, IL				10
11			Robinson Rehab & Nursing	Robinson, IL				11
12			Springfield Suites Rehab & Nursing	Springfield, IL				12
13			Twin Lakes Extended Care	Paris, IL				13
14			Northwoods Rehabilitation	Moravia, NY				14
15			Agawam North Rehab and Nursing	Agawam, MA				15
16			Agawam South Rehab and Nursing	Agawam, MA				16
17			Agawam East Rehab and Nursing	Agawam, MA				17
18			Agawam West Rehab and Nursing	Agawam, MA				18
19			Ayer Valley Rehab and Nursing	Ayer, MA				19
20			Andover Manor Rehab and Nursing	Andover, MA				20
21			Andover Forest Post Acute Care Center	North Andover, MA				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Benjamin Friedman	CFO	Administrative	15.00	See Att. Sch 7A	1.60	4.00	Alloc. Salary	\$ 5,368	17-7	1
2	Dina Hirsch	Controller	Administrative	2.00	See Att. Sch 7A	1.68	4.18	Alloc. Salary	8,197	21-7	2
3	Daniella Unger	Regional MDS Coord	Nursing	1.50	See Att. Sch 7A	1.68	4.18	Alloc. Salary	10,467	10-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 24,032		13

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

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

Facility Name & ID Number Countryside Care Center # 3000437 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 ☐

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

Name of Related Organization Stern Therapy Consultants, LLC
Street Address 7B Medical Park Drive
City / State / Zip Code Pomona, NY 10970
Phone Number (845) 414-3300
Fax Number (845) 517-4796

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Heat and Other Utilities	Evenly Over Units	23	23	\$ 10,705	\$	1	\$ 465	1
2	6	Maintenance	Evenly Over Units	23	23	26,392		1	1,147	2
3	19	Professional Services	Evenly Over Units	23	23	1,084,691		1	47,160	3
4	20	Dues, Fees, Subscriptions & Prom	Evenly Over Units	23	23	64,789		1	2,817	4
5	21	Clerical & General Office Expense	Evenly Over Units	23	23	227,348		1	9,885	5
6	24	Travel and Seminar	Evenly Over Units	23	23	72,075		1	3,134	6
7	25	Other Admin. Staff Transportatio	Evenly Over Units	23	23	253,068		1	11,003	7
8	26	Insurance-Prop.Liab.Malpractice	Evenly Over Units	23	23	27,342		1	1,189	8
9	33	Real Estate Taxes	Evenly Over Units	23	23	22,524		1	979	9
10	34	Rent-Facility & Grounds	Evenly Over Units	23	23	54,000		1	2,348	10
11								1		11
12										12
13	10	Nursing and Medical Records	Operating Months	24	21	1,749,468	1,749,468	1	72,895	13
14	15	Emp. Ben.-Nsg & Med	Operating Months	24	21	165,929		1	6,914	14
15	17	Administrative	Operating Months	24	21	802,749	802,749	1	33,448	15
16	21	Clerical & General Office Expense	Operating Months	24	21	1,699,900	1,699,900	1	70,829	16
17	27	Emp. Ben.-Gen. Admin.	Operating Months	24	21	237,364		1	9,890	17
18	39	Therapy Wages	Operating Months	24	21	1,759,324	1,759,324	1	73,305	18
19	39	Emp. Ben.-Therapy	Operating Months	24	21	166,863		1	6,953	19
20										20
21	17	Administrative	Operating Months	25	25	134,198	134,198	1	5,368	21
22	21	Clerical & General Office Expense	Operating Months	25	25	267,826	267,826	1	10,713	22
23	27	Emp. Ben.-Gen. Admin.	Operating Months	25	25	38,130		1	1,525	23
24										24
25	TOTALS					\$ 8,864,685	\$ 6,413,465		\$ 371,967	25

Facility Name & ID Number Countryside Care Center # 3000437 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 ☐

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

Name of Related Organization CET Office Holdings, LLC
Street Address 7B Medical Park Drive
City / State / Zip Code Pomona, NY 10970
Phone Number (845) 414-3300
Fax Number (845) 517-4796

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	20	Dues, Fees, Subscriptions & Prom	Evenly Over Units	23	23	\$ 25	\$	1	\$ 1	1
2	32	Interest Expense	Evenly Over Units	23	23	18,902		1	822	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					\$ 18,927	\$		\$ 823	25

Facility Name & ID Number Countryside Care Center # 3000437 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 ☐

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

Name of Related Organization Medwiz of Illinois, LLC
Street Address 167 Route 304
City / State / Zip Code Bardonia, NY 10954
Phone Number (845) 624-8080
Fax Number (845) 624-8055

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Pharmacy	Direct Cost	59,770	1	\$ 59,770	\$	59,770	\$ 59,770	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					\$ 59,770	\$		\$ 59,770	25

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	CBE Funding LLC	X		Mortgage	\$18,750.00	11/15/24	\$ 1,500,000	\$ 1,500,000	11/14/30	0.1500	\$ 225,000	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Intercompany Loan	X		Working Capital	\$12,500.00	11/15/24	1,000,000		11/14/30	0.1500	12,500	6	
7								Offset Intercompany Interest			(12,500)	7	
8												8	
9	TOTAL Facility Related				\$31,250.00		\$ 2,500,000	\$ 1,500,000			\$ 225,000	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(17,615)	10	
11								CET Office Holdings Alloc			822	11	
12								Disallow Related Party Interest Exp			(207,385)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (224,178)	14	
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 1,500,000			\$ 822	15	

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

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

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.)

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.			
1. Real Estate Tax accrual used on 2024 report.				\$	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.)				\$	3,812 2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,812 3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.		Allocated from Home Office			979
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.				\$	4,791 7
Assessed Value from Real Estate Tax Bill: 2024 198,748 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 22,867 13					
Facility does not accrue for real estate taxes.					
Line 2: 2024 Taxes		22867		16	16
Credit at Closing		-19055		17	17
Total		3812		17	17

		FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	\$		14
15	PLUS APPEAL COST FROM LINE 5	\$		15
16	LESS REFUND FROM LINE 6	\$		16
17	AMOUNT TO USE FOR RATE CALCULATION	\$		17

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.

FACILITY NAME	Countryside Care Center	COUNTY	McDonough
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CONTACT PERSON REGARDING THIS REPORT Larry Templin

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,290B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (X) (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2024	\$ 75,000	1
2	Alloc CET Office Holdings, LLC		1989	2,609	2
3	TOTALS			\$ 77,609	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62		2024	1970	\$ 425,000	\$	35	\$ 12,143	\$ 12,143	\$ 13,155	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install 98 Gallon BT-100 Water Heater			2025	4,668		20	117	117	117	9
10	Install 32 Channel COM System			2025	15,330		20	383	383	383	10
11	Install Carrier HE Ceiling Console & Outdoor Heat Pump System			2025	9,797		20	245	245	245	11
12	Install Door Alarms with New Server System			2025	6,875		20	172	172	172	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

Facility Name & ID Number Countryside Care Center

3000437

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2021	530		20	27	27	522	46
47	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2023	1,319		20	66	66	198	47
48	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2024	1,167		20	58	58	117	48
49	Allocated from Stern Therapy Consultants, LLC-Leasehold Improvements	2025	465		20	23	23	23	49
50	Allocated from CET Office Holdings, LLC - Building	1989	15,475		20	397	397	3,073	50
51	Allocated from CET Office Holdings, LLC-Leasehold Improvements	2018	4,457		20	223	223	1,709	51
52									52
53									53
54									54
55									55
56									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)		\$ 485,083	\$		\$ 13,854	\$ 13,854	\$ 19,714	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	27,661		1,383	1,383	10 yrs	1,383	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 27,661	\$	\$ 1,383	\$ 1,383		\$ 1,383	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 590,353	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,237	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,237	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,097	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: Petersen SNF Holdings
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:	<u>1970</u>	<u>62</u>	<u>11/1/24</u>	\$ <u>224,166</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		62		\$ 224,166			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 .
N/A
N/A
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 3,326 Description: Copier \$2,246; Dish Machine \$1,080
(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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

☒ 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
		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)	\$			

(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.

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	

(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

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(1)	2080	hrs	\$	73,050		\$	2,080	\$	73,050	1			
2	Licensed Speech and Language Development Therapist	39(1)	239	hrs		12,952			239		12,952	2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	39, (3)		hrs			52,648				52,648	4			
5	Physician Care			visits								5			
6	Dental Care			visits								6			
7	Work Related Program			hrs								7			
8	Habilitation			hrs								8			
9	Pharmacy	39(2)		# of prescrpts			62,759				62,759	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
11	Academic Education			hrs								11			
12	Other (specify): Lab/X-Ray	39(3)					947				947	12			
13	Other (specify): Home Office Allocation	39(7)				80,258					80,258	13			
14	TOTAL				\$	166,260		\$	53,595	\$	62,759	2,319	\$	282,614	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

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,049	\$ 68,112	1
2	Cash-Patient Deposits	8,192	8,192	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	651,406	651,406	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	497,051	497,051	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,165,698	\$ 1,224,761	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		77,609	13
14	Buildings, at Historical Cost		425,000	14
15	Leasehold Improvements, at Historical Cost		60,083	15
16	Equipment, at Historical Cost		27,661	16
17	Accumulated Depreciation (book methods)		(21,097)	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): <u>Closing Costs</u>		3,925	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 573,181	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,165,698	\$ 1,797,942	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,516	\$ 391,016	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,222	8,222	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,099	18,099	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 154,837	\$ 417,337	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	981,901		39
40	Mortgage Payable		1,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 981,901	\$ 1,500,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,136,738	\$ 1,917,337	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,960	\$ (119,395)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,165,698	\$ 1,797,942	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 57,178	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 57,178	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	331,782	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	(360,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (28,218)	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)	\$ 28,960	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Countryside Care Center

3000437

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,064,141	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,064,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	72,702	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 72,702	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	279	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	2,067	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,346	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,615	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,615	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Revenue Adjustment	63,480	28
28a	CNA Initiative	49,885	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 113,365	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,270,169	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	689,194	31
32	Health Care	1,706,953	32
33	General Administration	783,394	33
	B. Capital Expense		
34	Ownership	283,693	34
	C. Ancillary Expense		
35	Special Cost Centers	256,330	35
36	Provider Participation Fee	218,823	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,938,387	40
41	Income before Income Taxes (line 30 minus line 40)**	331,782	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 331,782	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 388,361.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,501,530.00	45
46	MMAI-Medicaid is the Primary Payer	296,662.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	20,640.00	48
49	Medicare Part A	699,096.00	49
50	Other-(specify) Insurance/Managed Care	157,852.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,064,141	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,234	2,324	\$ 103,795	\$ 44.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,223	5,258	250,690	47.68	3
4	Licensed Practical Nurses	8,198	8,466	336,351	39.73	4
5	CNAs & Orderlies	30,026	31,045	653,312	21.04	5
6	CNA Trainees					6
7	Licensed Therapist	2,203	2,319	86,002	37.09	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,822	4,923	80,380	16.33	10
11	Social Service Workers	1,885	2,080	40,314	19.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,232	13,328	218,214	16.37	15
16	Dishwashers					16
17	Maintenance Workers	1,601	1,616	31,665	19.59	17
18	Housekeepers	5,246	5,429	85,491	15.75	18
19	Laundry	4,292	4,442	69,947	15.75	19
20	Administrator	2,024	2,104	96,476	45.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,234	1,270	19,053	15.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	82,220	84,604	\$ 2,071,690 *	\$ 24.49	34

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	94	\$ 5,857	L1, C3	35
36	Medical Director	Monthly	8,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	94	\$ 13,857		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	885	\$ 40,723	L10, C3	50
51	Licensed Practical Nurses	1,385	68,910	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,270	\$ 109,633		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
William Stowers	Admininstrator	0	\$ 42,453
Janet Holmberg	Admininstrator	0	54,023
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 96,476
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 221,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 221,700
C. Professional Services			
Vendor/Payee	Type		Amount
Direct Supply	Life Safety Compliance	\$	1,143
IT Computing Services	Computer Service		2,253
Natl Datacare Corp	Fund Management		1,809
Pointclickcare	Computer Service		14,013
Streamline Verify LLC	Computer Service		394
Whentowork	Employee Scheduling Software		520
Bernath and Rosenberg, P.C	Accounting		2,580
Gutnicki	Legal Services		7,450
Parkwood Associates	401K Consultant		750
Accurate Pay	Payroll Services		4,302
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	35,214
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	17,803
Unemployment Compensation Insurance			42,206
FICA Taxes			158,310
Employee Health Insurance			83,924
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			5,037
TOTAL (agree to Schedule V, line 22, col.8)		\$	307,280
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		\$	2,035
Advertising: Employee Recruitment			26,000
Health Care Worker Background Check (Indicate # of checks performed)	2		63
Patient Background Checks	12		566
Association Dues (total from pg 22, #4)			
Licenses & Fees			1,445
Home Office/CET Office Holdings Alloc			2,818
Less: Public Relations Expense		(	)
PAC and Lobbying payments		(	)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	32,927
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			680
Home Office Allocation			3,134
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)		\$	3,814

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

	Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 13,738 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 218,823
This amount is to be recorded on line 42 of Schedule V.

(8) 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.
- (9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 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? N/A

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

(13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

(15) 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.