

Facility Name & ID Number Eastside Health & Rehabilitation Center

0047456 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,694	2,920	2,198	20,812	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,694	2,920	2,198	20,812	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.98%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

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 10/1/05

J. Was the facility purchased or leased after January 1, 1978?

YES

Date 10/1/05

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

If YES, enter number of beds certified 92 and days of care provided 2,198

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	110,159	8,477	3,360	121,996		121,996	4,191	126,187		1
2	Food Purchase		96,989		96,989		96,989	(715)	96,274		2
3	Housekeeping	69,976	10,198		80,174		80,174	20	80,194		3
4	Laundry	14,452	11,028	19	25,499		25,499	1	25,500		4
5	Heat and Other Utilities			85,993	85,993		85,993	297	86,290		5
6	Maintenance	32,678	14,108	21,061	67,847		67,847	2,443	70,290		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							2,838	2,838		7
8	TOTAL General Services	227,265	140,800	110,433	478,498		478,498	9,075	487,573		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	773,995	43,206	1,969	819,170		819,170	6,538	825,708		10
10a	Therapy		1,485	289,346	290,831		290,831		290,831		10a
11	Activities	30,042	927	622	31,591		31,591	(316)	31,275		11
12	Social Services	23,201	360		23,561		23,561		23,561		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							3,418	3,418		15
16	TOTAL Health Care and Programs	827,238	45,978	296,137	1,169,353		1,169,353	9,640	1,178,993		16
	C. General Administration										
17	Administrative	57,567		60,000	117,567		117,567	(37,032)	80,535		17
18	Directors Fees										18
19	Professional Services			9,070	9,070		9,070	6,409	15,479		19
20	Dues, Fees, Subscriptions & Promotions			5,787	5,787		5,787	553	6,340		20
21	Clerical & General Office Expenses	27,596	4,269	12,317	44,182		44,182	32,222	76,404		21
22	Employee Benefits & Payroll Taxes			177,617	177,617		177,617		177,617		22
23	Inservice Training & Education			206	206		206	340	546		23
24	Travel and Seminar			30	30		30	541	571		24
25	Other Admin. Staff Transportation			2,360	2,360		2,360	3,522	5,882		25
26	Insurance-Prop.Liab.Malpractice			14,345	14,345		14,345	797	15,142		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							16,785	16,785		27
28	TOTAL General Administration	85,163	4,269	281,732	371,164		371,164	24,137	395,301		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,139,666	191,047	688,302	2,019,015		2,019,015	42,852	2,061,867		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.

Facility Name & ID Number Eastside Health & Rehabilitation Center

#0047456

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			71,492	71,492		71,492	695	72,187			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,887	61,887		61,887	47,711	109,598			32
33	Real Estate Taxes			80,641	80,641		80,641	681	81,322			33
34	Rent-Facility & Grounds							42	42			34
35	Rent-Equipment & Vehicles			17,963	17,963		17,963	548	18,511			35
36	Other (specify):*											36
37	TOTAL Ownership			231,983	231,983		231,983	49,677	281,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,858		46,858		46,858		46,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,172	50,172		50,172		50,172			42
43	Other (specify):* Non-allowable Cost		461	80,252	80,713		80,713	(80,713)				43
44	TOTAL Special Cost Centers		47,319	130,424	177,743		177,743	(80,713)	97,030			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,139,666	238,366	1,050,709	2,428,741		2,428,741	11,816	2,440,557			45

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

**See schedule of adjustments attached at end of cost 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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(775)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,759)	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	(2,553)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(568)	43		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	(2,925)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,009)	43		24
25	Fund Raising, Advertising and Promotional	(9,572)	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 <u>See Pg. 5A</u>	(10,476)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (85,687)		\$	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	2	
		Amount	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)	97,503	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 97,503		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 11,816		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Eastside Health & Rehabilitation Center

ID# 0047456

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,418)	43	1
2	X-Rays-Part A	(840)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(945)	10	3
4	Offset Transportation Revenue	(316)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(110)	21	5
6	Offset Chamber of Commerce Dues	(275)	20	6
7	Resident Flower	(675)	43	7
8	Disallowed Special Events	(897)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(10,476)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastside Health & Rehabilitation Center# 0047456

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,742	0	2,449	0	0	0	0	0	0	0	4,191	1
2	Food Purchase	(775)	60	0	0	0	0	0	0	0	0	0	(715)	2
3	Housekeeping	0	20	0	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	297	0	0	0	0	0	0	0	0	0	297	5
6	Maintenance	0	2,426	0	17	0	0	0	0	0	0	0	2,443	6
7	Other (specify):*	0	795	0	2,043	0	0	0	0	0	0	0	2,838	7
8	TOTAL General Services	(775)	5,341	0	4,509	0	9,075	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	(945)	4,605	0	2,878	0	0	0	0	0	0	0	6,538	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(316)	0	0	0	0	0	0	0	0	0	0	(316)	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	1,024	0	2,394	0	0	0	0	0	0	0	3,418	15
16	TOTAL Health Care and Programs	(1,261)	5,629	0	5,272	0	9,640	16						
	C. General Administration													
17	Administrative	0	(47,036)	0	10,004	0	0	0	0	0	0	0	(37,032)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,519	0	2,890	0	0	0	0	0	0	0	6,409	19
20	Fees, Subscriptions & Promotions	(275)	0	763	65	0	0	0	0	0	0	0	553	20
21	Clerical & General Office Expenses	(110)	0	29,520	2,812	0	0	0	0	0	0	0	32,222	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	340	0	0	0	0	0	0	0	0	340	23
24	Travel and Seminar	0	0	540	1	0	0	0	0	0	0	0	541	24
25	Other Admin. Staff Transportation	0	0	1,958	1,564	0	0	0	0	0	0	0	3,522	25
26	Insurance-Prop.Liab.Malpractice	0	0	797	0	0	0	0	0	0	0	0	797	26
27	Other (specify):*	0	0	8,441	8,344	0	0	0	0	0	0	0	16,785	27
28	TOTAL General Administration	(385)	(43,517)	42,359	25,680	0	24,137	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,421)	(32,547)	42,359	35,461	0	42,852	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastside Health & Rehabilitation Center# 0047456

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,553)	0	2,067	1,181	0	0	0	0	0	0	0	695	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3,593	44,118	0	0	0	0	0	0	0	47,711	32
33	Real Estate Taxes	0	0	681	0	0	0	0	0	0	0	0	681	33
34	Rent-Facility & Grounds	0	0	42	0	0	0	0	0	0	0	0	42	34
35	Rent-Equipment & Vehicles	0	0	548	0	0	0	0	0	0	0	0	548	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,553)	0	6,931	45,299	0	49,677	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(80,713)	0	0	0	0	0	0	0	0	0	0	(80,713)	43
44	TOTAL Special Cost Centers	(80,713)	0	0	0	0	0	0	0	0	0	0	(80,713)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(85,687)	(32,547)	49,290	80,760	0	11,816	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,742	\$ 1,742	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	60	60	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	20	20	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	297	297	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,426	2,426	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	795	795	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,605	4,605	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,024	1,024	10
11	V	17 Administrative	60,000	Petersen Health Care, Inc.	100.00%	12,964	(47,036)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,519	3,519	12
13	V							13
14	Total		\$ 60,000			\$ 27,453	\$ * (32,547)	14

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

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, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 763	\$	763	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,520		29,520	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	340		340	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	540		540	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,958		1,958	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	797		797	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,441		8,441	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,067		2,067	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,593		3,593	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	681		681	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	42		42	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	548		548	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		\$			\$ 49,290	\$ *	49,290	39

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

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	1 <u>Dietary</u>	\$	Petersen Health Operations, LLC	100.00%	\$ 2,449	\$	2,449	15
16	V	2 <u>Food</u>		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 <u>Laundry</u>		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 <u>Utilities</u>		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		Petersen Health Operations, LLC	100.00%	17		17	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	2,043		2,043	21
22	V	10 <u>Nursing and Medical Records</u>		Petersen Health Operations, LLC	100.00%	2,878		2,878	22
23	V	10A <u>Therapy</u>		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	2,394		2,394	24
25	V	17 <u>Administrative</u>		Petersen Health Operations, LLC	100.00%	10,004		10,004	25
26	V	19 <u>Professional Services</u>		Petersen Health Operations, LLC	100.00%	2,890		2,890	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		Petersen Health Operations, LLC	100.00%	65		65	27
28	V	21 <u>Clerical and General Office</u>		Petersen Health Operations, LLC	100.00%	2,812		2,812	28
29	V	23 <u>Inservice Training and Education</u>		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 <u>Travel and Seminar</u>		Petersen Health Operations, LLC	100.00%	1		1	30
31	V	25 <u>Other Admin. Staff Transportation</u>		Petersen Health Operations, LLC	100.00%	1,564		1,564	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	8,344		8,344	33
34	V	30 <u>Depreciation</u>		Petersen Health Operations, LLC	100.00%	1,181		1,181	34
35	V	32 <u>Interest</u>		Petersen Health Operations, LLC	100.00%	44,118		44,118	35
36	V	33 <u>Real Estate Taxes</u>		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 80,760	\$ *	80,760	39

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

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.85	1.55	Salary	\$ 12,964	L17, C7	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	\$ 12,964		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 Eastside Health & Rehabilitation Center

0047456

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	20,812	\$ 1,742	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	20,812	60	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	20,812	20	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	20,812	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	20,812	297	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	20,812	2,426	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	20,812	795	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	20,812	4,605	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	20,812	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	20,812	1,024	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	20,812	12,964	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	20,812	3,519	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	20,812	763	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	20,812	29,520	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	20,812	340	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	20,812	540	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	20,812	1,958	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	20,812	797	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	20,812	8,441	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	20,812	2,067	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	20,812	3,593	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	20,812	681	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	20,812	42	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	20,812	548	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 76,743	25

Facility Name & ID Number Eastside Health & Rehabilitation Center

0047456

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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

Name of Related Organization Petersen Health Operations, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

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	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	20,812	\$ 2,449	1
2	2	Food	Resident Days	440,525	23			20,812		2
3	3	Housekeeping	Resident Days	440,525	23			20,812		3
4	4	Laundry	Resident Days	440,525	23			20,812		4
5	5	Utilities	Resident Days	440,525	23			20,812		5
6	6	Maintenance	Resident Days	440,525	23	358		20,812	17	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		20,812	2,043	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	20,812	2,878	8
9	10A	Therapy	Resident Days	440,525	23			20,812		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		20,812	2,394	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	20,812	10,004	11
12	19	Professional Services	Resident Days	440,525	23	61,162		20,812	2,890	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		20,812	65	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		20,812	2,812	14
15	23	Inservice Training & Education	Resident Days	440,525	23			20,812		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		20,812	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		20,812	1,564	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			20,812		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		20,812	8,344	19
20	30	Depreciation	Resident Days	440,525	23	24,996		20,812	1,181	20
21	32	Interest	Resident Days	440,525	23	933,842		20,812	44,118	21
22	33	Real Estate Taxes	Resident Days	440,525	23			20,812		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			20,812		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			20,812		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 80,760	25

Facility Name & ID Number

Eastside Health & Rehabilitation Center

0047456

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 375,000	\$ 371,447	12/31/13	Varies	\$ 61,887	1					
2												2					
3							Home Office Allocation-PHC				3,593	3					
4							Home Office Allocation-PHO				44,118	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 375,000	\$ 371,447			\$ 109,598	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 375,000	\$ 371,447			\$ 109,598	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.)

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 2006 report.		\$	69,000	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.)	2006	\$	73,641	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,641	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	76,000	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. Home Office Allocation			681	
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.		\$	81,322	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	8
	2003	9
	2004	10
	2005	68,978 11
	2006	73,641 12

Accrual based on prior year tax bill.

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$ 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastside Health & Rehabilitation Center COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0047456

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>53-033-05</u>	<u>Long-Term Care Facility</u>	\$ <u>73,641.00</u>	\$ <u>73,641.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>73,641.00</u>	\$ <u>73,641.00</u>

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? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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: 30,894 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>Facility</u>	<u>242,194</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	242,194		\$ 54,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99	2005	1970	\$ 959,500	\$	25	\$ 38,380	\$ 38,380	\$ 95,950
5									
6									
7	Home Office Allocation			11,603			283	283	
8									
Improvement Type**									
9									
10	Original Land		2005	21,000		15	1,150	1,150	2,800
11	Blinds		2007	7,233		10	362	362	362
12	Smoke Alarms/Detectors		2007	5,580		10	279	279	279
13									
14									
15									
16									
17	Building Booked				38,405			(38,405)	
18	Building Improvement Booked				2,844			(2,844)	
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			776			46	46	
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
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								49
50								50
51								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)	\$	\$		\$	\$	\$	70
		1,005,692	41,249		40,500	(749)	99,391	

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 196,953	\$ 30,071	\$ 28,479	\$ (1,592)	5-7	\$ 72,230	71
72	Current Year Purchases	5,777	172	289	117	10	289	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,919	2,919			74
75	TOTALS	\$ 202,730	\$ 30,243	\$ 31,687	\$ 1,444		\$ 72,519	75

D. Vehicle Depreciation (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)	\$ 1,262,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,492	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,187	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 695	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,910	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: 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		<u>Home Office Allocation</u>			<u>42</u>			6
7	TOTAL				\$ <u>42</u>			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: _____ *

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: \$ 18,511 Description: See Schedule 14A

(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			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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.

Eastside Health & Rehabilitation Center

0047456

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 13,333
Dishwasher	561
Laundry Equipment	11
Copier	4,058
Home Office Allocation	548
	<u>18,511</u>
	<u><u>18,511</u></u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	10A(3)	hrs	\$	7,643	\$ 114,650	\$	7,643	\$ 114,650	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,499	22,486		1,499	22,486	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2) & 10A(3)	hrs		10,147	152,210	1,485	10,147	153,695	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 prescripts				46,858		46,858	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	19,289	\$ 289,346	\$ 48,343	19,289	\$ 337,689	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 Eastside Health & Rehabilitation Center

0047456

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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	\$ (748,651)	\$ (748,651)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	593,082	593,082	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,084	14,084	6
7	Other Prepaid Expenses	8,232	8,232	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (133,253)	\$ (133,253)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	69,000	54,000	13
14	Buildings, at Historical Cost	959,500	971,103	14
15	Leasehold Improvements, at Historical Cost	7,233	34,589	15
16	Equipment, at Historical Cost	208,309	202,730	16
17	Accumulated Depreciation (book methods)	(155,329)	(171,910)	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): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,088,713	\$ 1,090,512	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 955,460	\$ 957,259	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 309,080	\$ 309,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,003	22,003	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,037	7,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,000	76,000	32
33	Accrued Interest Payable	2,328	2,328	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	18,966	18,966	36
37	<u>Due to Related Parties</u>	80,419	80,419	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 515,833	\$ 515,833	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	371,447	371,447	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)	\$ 371,447	\$ 371,447	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 887,280	\$ 887,280	46
47	TOTAL EQUITY(page 18, line 24)	\$ 68,180	\$ 69,979	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 955,460	\$ 957,259	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (131,016)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (131,016)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,196	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	()	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)	\$ 199,196	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)	\$ 68,180	24 *

* This must agree with page 17, line 47.

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,879,267	1
2	Discounts and Allowances for all Levels	245,851	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,125,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	394,079	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 394,079	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	775	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,146	20
21	Other Medical Services	13,040	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 107,369	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,055	28
28a	Transportation Revenue	316	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,371	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,627,937	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	478,498	31
32	Health Care	1,169,353	32
33	General Administration	371,164	33
	B. Capital Expense		
34	Ownership	231,983	34
	C. Ancillary Expense		
35	Special Cost Centers	127,571	35
36	Provider Participation Fee	50,172	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,428,741	40
41	Income before Income Taxes (line 30 minus line 40)**	199,196	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,196	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

*** 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 Eastside Health & Rehabilitation Center

0047456

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,773	1,893	\$ 46,073	\$ 24.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,911	1,931	38,589	19.98	3
4	Licensed Practical Nurses	16,783	17,202	265,892	15.46	4
5	CNAs & Orderlies	38,485	39,421	359,630	9.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,015	20,063	9.96	9
10	Activity Assistants	969	969	7,212	7.44	10
11	Social Service Workers	2,088	2,088	23,201	11.11	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,632	10.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,587	10,878	87,527	8.05	15
16	Dishwashers					16
17	Maintenance Workers	2,288	2,385	32,678	13.70	17
18	Housekeepers	8,995	9,308	69,976	7.52	18
19	Laundry	1,483	1,603	14,452	9.02	19
20	Administrator	2,080	2,080	57,567	27.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,014	2,014	27,596	13.70	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	4,134	4,252	66,578	15.66	33
34	TOTAL (lines 1 - 33)	97,590	100,119	\$ 1,139,666 *	\$ 11.38	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	64	\$ 3,360	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,120	10(3)	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)	64	\$ 8,680		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Eastside Health & Rehabilitation Center
 0047456
 Period Beginning 01/01/2007
 Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	39,746	19.11
Transportation	249	249	2,767	11.11
Restorative Aide	1,805	1,923	24,065	12.51
Total Line 32-Other	4,134	4,252	66,578	15.66

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Teresa Bauer	Administrator	0	\$ 57,567	Workers' Compensation Insurance	\$ 15,000	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	52,606	Advertising: Employee Recruitment	320	
				FICA Taxes	83,614	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	21,456	Patient Background Checks	68	
				Employee Meals		Miscellaneous Dues & Subscriptions	275	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	828	
				Employee Relations	3,993	Misc. Licenses & Permits-Refund	(126)	
				Employee Retirement	948	LTC Solutions License	1,600	
						IHCA Dues	2,043	
						Less: Public Relations Expense	(275)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,567	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 177,617		\$ 6,340		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 60,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,000				Seminar Expense	30
							Home Office Allocation	541
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,070	TOTAL		\$	TOTAL	\$ 571

* Attach copy of IMRF notifications

**See instructions.

Eastside Health & Rehabilitation Center

0047456

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
---------------------	-------------	---------------

Total (agree to Schedule V, line 19, column 3)		9,070
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Home Office Allocation

Pearl & Associates	Legal	23
Addy Bush & Assoc	Legal	12
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	51
Duane Morris	Legal	79
Ginoli & Co.	Accountants	2,592
RSM McGladrey	Accountants	139
McGladrey & Pullen	Accountants	212
Emdeon Business Services	Computer Services	55
Advanced Answers on Demand	Computer Services	1,492
Access 2 Go	Computer Services	113
Ivans	Computer Services	500
Kemper Technology	Computer Services	234
Adminastar Federal	Computer Services	29
LogmeIn	Computer Services	18
E-Health Data Solutions	Computer Services	146
Miscellaneous Vendors	Computer Services	18
Julie Breedlove	Computer Services	17
Amerisearch	Employment Fees	677

Total (agree to Schedule V, line 19, column 8)		<u>15,479</u>
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Facility Name & ID Number Eastside Health & Rehabilitation Center

0047456

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$2,043
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,838 Line 10
- (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. \$ 50,172
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. \$ 775
- (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? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- 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
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees