



Facility Name & ID Number Eastside Health & Rehabilitation Center

# 0047456 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	33,672	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	33,672	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	13,789	3,467	2,936	20,192	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,789	3,467	2,936	20,192	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.97%

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 2,936

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	113,438	10,315	463	124,216		124,216	3,589	127,805		1
2	Food Purchase		104,348		104,348		104,348	62	104,410		2
3	Housekeeping	78,058	11,812		89,870		89,870	27	89,897		3
4	Laundry	372	7,732	26	8,130		8,130	2	8,132		4
5	Heat and Other Utilities			87,118	87,118		87,118	372	87,490		5
6	Maintenance	33,292	22,063	21,062	76,417		76,417	3,295	79,712		6
7	Other (specify):* Home Off. Ben. All.							1,222	1,222		7
8	<b>TOTAL General Services</b>	225,160	156,270	108,669	490,099		490,099	8,569	498,668		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	778,165	49,365	3,846	831,376		831,376	4,987	836,363		10
10a	Therapy		100	373,129	373,229		373,229		373,229		10a
11	Activities	27,249	83	92	27,424		27,424		27,424		11
12	Social Services	23,977			23,977		23,977	9	23,986		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,088	1,088		15
16	<b>TOTAL Health Care and Programs</b>	829,391	49,548	381,267	1,260,206		1,260,206	6,084	1,266,290		16
	<b>C. General Administration</b>										
17	Administrative	57,686		134,000	191,686		191,686	(103,868)	87,818		17
18	Directors Fees										18
19	Professional Services			8,614	8,614		8,614	5,981	14,595		19
20	Dues, Fees, Subscriptions & Promotions			5,987	5,987		5,987	721	6,708		20
21	Clerical & General Office Expenses	28,655	4,070	7,109	39,834		39,834	40,175	80,009		21
22	Employee Benefits & Payroll Taxes			130,920	130,920		130,920		130,920		22
23	Inservice Training & Education			239	239		239	227	466		23
24	Travel and Seminar							227	227		24
25	Other Admin. Staff Transportation			2,150	2,150		2,150	7,863	10,013		25
26	Insurance-Prop.Liab.Malpractice			18,706	18,706		18,706	168	18,874		26
27	Other (specify):* Home Off. Ben. All.							11,531	11,531		27
28	<b>TOTAL General Administration</b>	86,341	4,070	307,725	398,136		398,136	(36,975)	361,161		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,140,892	209,888	797,661	2,148,441		2,148,441	(22,322)	2,126,119		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:

1/1/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			74,360	74,360		74,360	1,952	76,312			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,335	24,335		24,335	12,752	37,087			32
33	Real Estate Taxes			77,509	77,509		77,509	512	78,021			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,800	35,800		35,800	437	36,237			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			212,004	212,004		212,004	15,653	227,657			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		89,859		89,859		89,859		89,859			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,508	50,508		50,508		50,508			42
43	Other (specify):* <b>Non-allowable Cost</b>		281	44,714	44,995		44,995	(44,995)				43
44	<b>TOTAL Special Cost Centers</b>		90,140	95,222	185,362		185,362	(44,995)	140,367			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,140,892	300,028	1,104,887	2,545,807		2,545,807	(51,664)	2,494,143			45

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



Eastside Health & Rehabilitation Center

ID# 0047456

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (11,859)	43	1
2	X-Rays-Part A	(1,912)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,243)	10	3
4	Resident Flowers	(357)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(311)	21	5
6	Offset Chamber of Commerce Dues	(300)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(15,982)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	3,589	0	0	0	0	0	0	0	0	0	3,589	1
2	Food Purchase	0	59	0	3	0	0	0	0	0	0	0	62	2
3	Housekeeping	0	27	0	0	0	0	0	0	0	0	0	27	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	372	0	0	0	0	0	0	0	0	0	372	5
6	Maintenance	0	2,193	0	1,102	0	0	0	0	0	0	0	3,295	6
7	Other (specify):*	0	882	0	340	0	0	0	0	0	0	0	1,222	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>7,124</b>	<b>0</b>	<b>1,445</b>	<b>0</b>	<b>8,569</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,243)	6,229	0	1	0	0	0	0	0	0	0	4,987	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	9	0	0	0	0	0	0	0	9	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	1,088	0	0	0	0	0	0	0	0	0	1,088	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,243)</b>	<b>7,317</b>	<b>0</b>	<b>10</b>	<b>0</b>	<b>6,084</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(106,060)	0	2,192	0	0	0	0	0	0	0	(103,868)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,153	0	2,828	0	0	0	0	0	0	0	5,981	19
20	Fees, Subscriptions & Promotions	(300)	0	973	48	0	0	0	0	0	0	0	721	20
21	Clerical & General Office Expenses	(311)	0	35,062	5,424	0	0	0	0	0	0	0	40,175	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	213	14	0	0	0	0	0	0	0	227	23
24	Travel and Seminar	0	0	213	14	0	0	0	0	0	0	0	227	24
25	Other Admin. Staff Transportation	0	0	2,761	5,102	0	0	0	0	0	0	0	7,863	25
26	Insurance-Prop.Liab.Malpractice	0	0	168	0	0	0	0	0	0	0	0	168	26
27	Other (specify):*	0	0	9,982	1,549	0	0	0	0	0	0	0	11,531	27
28	<b>TOTAL General Administration</b>	<b>(611)</b>	<b>(102,907)</b>	<b>49,372</b>	<b>17,171</b>	<b>0</b>	<b>(36,975)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(1,854)</b>	<b>(88,466)</b>	<b>49,372</b>	<b>18,626</b>	<b>0</b>	<b>(22,322)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	(3,122)	0	3,820	1,254	0	0	0	0	0	0	0	1,952	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(165)	0	2,687	10,230	0	0	0	0	0	0	0	12,752	32
33	Real Estate Taxes	0	0	512	0	0	0	0	0	0	0	0	512	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	437	0	0	0	0	0	0	0	0	437	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,287)</b>	<b>0</b>	<b>7,456</b>	<b>11,484</b>	<b>0</b>	<b>15,653</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(44,995)	0	0	0	0	0	0	0	0	0	0	(44,995)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(44,995)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(44,995)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(50,136)</b>	<b>(88,466)</b>	<b>56,828</b>	<b>30,110</b>	<b>0</b>	<b>(51,664)</b>	<b>45</b>						

**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%	\$ 3,589	\$ 3,589	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	59	59	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	27	27	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	372	372	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,193	2,193	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	882	882	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,229	6,229	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,088	1,088	10
11	V	17 Administrative	134,000	Petersen Health Care, Inc.	100.00%	27,940	(106,060)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,153	3,153	12
13	V							13
14	Total		\$ 134,000			\$ 45,534	\$ * (88,466)	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%	\$ 973	\$ 973	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,062	35,062	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	213	213	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	213	213	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,761	2,761	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	168	168	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,982	9,982	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,820	3,820	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,687	2,687	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	512	512	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	437	437	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	<b>Total</b>		\$				\$ 56,828	\$ * 56,828	39

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

Facility Name & ID Number Eastside Health & Rehabilitation Center# 0047456Report Period Beginning: 1/1/2008Ending: 12/31/2008

## 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 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$		15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	3	3	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,102	1,102	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	340	340	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1	1	22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	9	9	23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	2,192	2,192	24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,828	2,828	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	48	48	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	5,424	5,424	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	14	14	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	14	14	30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	5,102	5,102	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,549	1,549	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,254	1,254	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	10,230	10,230	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total		\$			\$ 30,110	\$ * 30,110	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: 1/1/2008 Ending: 12/31/2008

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	1,800,734	0.84	1.40	Salary	27,940	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	\$ 27,940		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 &amp; ID Number Eastside Health &amp; Rehabilitation Center

# 0047456

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

## 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 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

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	1,413,604	69	\$ 251,260	\$ 250,687	20,192	\$ 3,589	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	20,192	59	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	20,192	27	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	20,192	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	20,192	372	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	20,192	2,193	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	20,192	882	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	20,192	6,229	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	20,192	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	20,192	1,088	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	20,192	27,940	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	20,192	3,153	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	20,192	973	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	20,192	35,062	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	20,192	213	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	20,192	213	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	20,192	2,761	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	20,192	168	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	20,192	9,982	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	20,192	3,820	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	20,192	2,687	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	20,192	512	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	20,192	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	20,192	437	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 102,362	25

Facility Name & ID Number Eastside Health & Rehabilitation Center

# 0047456

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

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	419,957	23	\$	20,192	\$	1
2	2	Food	Resident Days	419,957	23	68	20,192	3	2
3	3	Housekeeping	Resident Days	419,957	23		20,192		3
4	4	Laundry	Resident Days	419,957	23		20,192		4
5	5	Utilities	Resident Days	419,957	23		20,192		5
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	1,102	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	20,192	340	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	20,192	1	8
9	12	Social Services	Resident Days	419,957	23	187	20,192	9	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	2,192	10
11	19	Professional Services	Resident Days	419,957	23	58,812	20,192	2,828	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	20,192	48	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	20,192	5,424	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		20,192		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299	20,192	14	15
16	24	Travel and Seminar	Resident Days	419,957	23	296	20,192	14	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	20,192	5,102	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		20,192		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	20,192	1,549	19
20	30	Depreciation	Resident Days	419,957	23	26,070	20,192	1,254	20
21	32	Interest	Resident Days	419,957	23	212,765	20,192	10,230	21
22	33	Real Estate Taxes	Resident Days	419,957	23		20,192		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		20,192		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		20,192		24
25	TOTALS					\$ 626,192	\$ 55,582	\$ 30,110	25

Facility Name & ID Number

Eastside Health & Rehabilitation Center

# 0047456

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 375,000	\$ 367,247	12/31/13	Varies	\$ 24,335	1					
2												2					
3							Interest Income Offset				(165)	3					
4							Home Office Allocation-PHC				2,687	4					
5							Home Office Allocation-PHO				10,230	5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 375,000	\$ 367,247			\$ 37,087	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 375,000	\$ 367,247			\$ 37,087	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>75,509.00</u>	\$ <u>75,509.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>75,509.00</u>	\$ <u>75,509.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>242,194</u>	<u>2005</u>	<u>\$ 54,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>242,194</b>		<b>\$ 54,000</b>	<b>3</b>

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	\$ 134,330	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9										9
10	Original Land		2005	21,000		15	1,150	1,150	3,950	10
11	Blinds		2007	7,233		10	723	723	1,085	11
12	Smoke Alarms/Detectors		2007	5,580		10	558	558	837	12
13	Generator		2008	19,174		7	1,370	1,370	1,370	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	Building Booked				38,405			(38,405)		28
29	Building Improvement Booked				4,544			(4,544)		29
30										30
31	2008-Home Office Allocation-Building Improvements			10,484			251	251		31
32	2008-Home Office Allocation-Land Improvements			701			45	45		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.

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)	\$ 1,023,672	\$ 42,949		\$ 42,477	\$ (472)	\$ 141,572	70

\*\*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	\$ 202,730	\$ 31,411	\$ 29,057	\$ (2,354)		\$ 101,576	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,778	4,778			74
75	TOTALS	\$ 202,730	\$ 31,411	\$ 33,835	\$ 2,424		\$ 101,576	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)	\$ 1,280,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,360	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,312	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,952	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 243,148	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				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								6
7	TOTAL				\$			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: \$ 14,267 Description: See Attached 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	Facility	2006 Ford E250	578.17	21,970	18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 21,970	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 1/1/2008**

**Period End 12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 6,934
Dishwasher	708
Maintenance Equipment	125
Copier	6,063
Home Office Allocation	437
	<u>14,267</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? <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	\$	10,032	\$ 150,476	\$	10,032	\$ 150,476	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,560	38,402		2,560	38,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		12,283	184,251	100	12,283	184,351	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				89,859		89,859	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	24,875	\$ 373,129	\$ 89,959	24,875	\$ 463,088	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (31,264)	\$ (31,264)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	566,477	566,477	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,868	22,868	6
7	Other Prepaid Expenses	8,177	8,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 566,258	\$ 566,258	10
	<b>B. Long-Term Assets</b>			
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	969,984	14
15	Leasehold Improvements, at Historical Cost	26,406	53,688	15
16	Equipment, at Historical Cost	208,309	202,730	16
17	Accumulated Depreciation (book methods)	(229,689)	(243,148)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,033,526	\$ 1,037,254	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,599,784	\$ 1,603,512	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 463,265	\$ 463,265	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,490	21,490	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,373	4,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,000	78,000	32
33	Accrued Interest Payable	1,838	1,838	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	19,106	19,106	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 588,072	\$ 588,072	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	367,247	367,247	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P - Prior Owner</u>	5,460	5,460	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 372,707	\$ 372,707	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 960,779	\$ 960,779	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 639,005	\$ 642,733	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,599,784	\$ 1,603,512	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>68,180</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>	<b>Rounding</b>	<b>(1)</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>68,179</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>570,826</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>570,826</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>639,005</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,167,426	1
2	Discounts and Allowances for all Levels	231,349	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,398,775	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	519,197	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 519,197	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	151,182	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,736	20
21	Other Medical Services	26,024	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 196,942	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	165	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 165	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	1,554	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,554	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,116,633	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	490,099	31
32	Health Care	1,260,206	32
33	General Administration	398,136	33
	<b>B. Capital Expense</b>		
34	Ownership	212,004	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	134,854	35
36	Provider Participation Fee	50,508	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,545,807	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	570,826	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 570,826	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 part of 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: 1/1/2008

Ending: 12/31/2008

**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	2,080	2,080	\$ 51,742	\$ 24.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,077	2,077	42,464	20.44	3
4	Licensed Practical Nurses	13,558	14,109	222,030	15.74	4
5	CNAs & Orderlies	40,227	41,666	394,428	9.47	5
6	CNA Trainees					6
7	Licensed Therapist	1,833	2,008	26,682	13.29	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,843	2,020	20,051	9.93	9
10	Activity Assistants	98	98	695	7.09	10
11	Social Service Workers	2,080	2,080	23,977	11.53	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,172	11.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,598	10,977	90,266	8.22	15
16	Dishwashers					16
17	Maintenance Workers	2,203	2,293	33,292	14.52	17
18	Housekeepers	9,868	10,158	78,058	7.68	18
19	Laundry	41	47	372	7.91	19
20	Administrator	2,080	2,080	57,686	27.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	28,655	13.78	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 C: <u>Transportation</u>	552	552	6,503	11.78	32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	40,819	19.62	33
34	TOTAL (lines 1 - 33)	95,378	98,485	\$ 1,140,892 *	\$ 11.58	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	8	\$ 463	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	1,200	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)	8	\$ 5,863		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

**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	
<u>Theresa Bauer</u>	<u>Administrator</u>	<u>0</u>	\$ <u>57,686</u>	<u>Workers' Compensation Insurance</u>	\$ <u>23,245</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>37,815</u>	<u>Advertising: Employee Recruitment</u>	<u>122</u>	
				<u>FICA Taxes</u>	<u>84,291</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>(17,198)</u>	(Indicate # of checks performed )		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>81</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Permits</u>	<u>445</u>	
				<u>Employee Relations</u>	<u>1,529</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>300</u>	
				<u>Employee Retirement</u>	<u>1,238</u>	<u>IHCA Dues</u>	<u>2,320</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>57,686</u></b>			<u>Home Office Allocation</u>	<u>1,021</u>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 134,000</u>	\$ <u>130,920</u>			\$ <u>6,708</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>134,000</u></b>					
<b>(Attach a copy of any management service agreement)</b>								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>E-Data Health</u>	<u>Computer Services</u>		<u>\$ 2,700</u>				<u>Out-of-State Travel</u>	\$
<u>Verizon North</u>	<u>Computer Services</u>		<u>928</u>					
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,600</u>				<u>In-State Travel</u>	
<u>Lindon Engineering</u>	<u>Accounting Services</u>		<u>3,386</u>					
				<u>N/A</u>				
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>227</u>
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>8,614</u></b>	<b>\$</b>			<b>(agree to Sch. V, line 24, col. 8)</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>\$ <u>227</u></b>	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Eastside Health & Rehabilitation Center**

**0047456**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		8,614

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	231
GoffWilson, P.A.	Legal	383
Ginoli & Company	Accountants	3,203
RSM McGladrey	Accountants	9
Miscellaneous Vendors	Computer Services	45
Emdeon Business Services	Computer Services	62
Advanced Answers on Demand	Computer Services	725
Access 2 Go	Computer Services	214
Ivans	Computer Services	495
Kemper Technology	Computer Services	392
VisionShare	Computer Services	42
Logmein	Computer Services	30
Comm Net Communiations	Computer Services	11
Charter Communications	Computer Services	9
Advanced System Designs	Computer Services	14
Consolidated Communications	Computer Services	8
Miscellaneous Vendors	Miscellaneous	108

Total (agree to Schedule V, line 19, column 8)		<u>14,595</u>
--	--	---------------

**Eastside Health & Rehabilitation Center**

**0047456**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Theresa Bauer	Administrator	0	57,686
	<b>Total</b>		<u><u>57,686</u></u>



Facility Name &amp; ID Number Eastside Health &amp; Rehabilitation Center

# 0047456

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

**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. 2,320 -IHCA
- (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? No
- (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. \$ 10,818 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? N/A  
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. \$ 50,508  
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? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ No
- 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (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 currently 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