

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,807	5,025	1,936	18,768	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,807	5,025	1,936	18,768	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.89%

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

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 10/1/2005

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

YES Date 10/1/2005 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 1,639

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Eastside Health & Rehab Ctr # 0047456 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	121,057	12,700		133,757		133,757	3,855	137,612		1
2	Food Purchase		126,057		126,057		126,057	(116)	125,941		2
3	Housekeeping	101,111	14,277		115,388		115,388	67	115,455		3
4	Laundry	14,529	3,769		18,298		18,298		18,298		4
5	Heat and Other Utilities			81,382	81,382		81,382	225	81,607		5
6	Maintenance	39,110	(59)	18,339	57,390		57,390	11,480	68,870		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	275,807	156,744	99,721	532,272		532,272	15,511	547,783		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	899,931	76,508	4,358	980,797		980,797	(2,867)	977,930		10
10a	Therapy			275,899	275,899		275,899		275,899		10a
11	Activities	20,558	28	108	20,694		20,694	(11,312)	9,382		11
12	Social Services	30,652			30,652		30,652		30,652		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	951,141	76,536	287,565	1,315,242		1,315,242	(14,179)	1,301,063		16
	C. General Administration										
17	Administrative			243,900	243,900		243,900	(183,900)	60,000		17
18	Directors Fees										18
19	Professional Services			1,932	1,932		1,932	24,525	26,457		19
20	Dues, Fees, Subscriptions & Promotions			9,225	9,225		9,225	80	9,305		20
21	Clerical & General Office Expenses	14,544	3,125	9,803	27,472		27,472	45,071	72,543		21
22	Employee Benefits & Payroll Taxes			156,230	156,230		156,230	25,244	181,474		22
23	Inservice Training & Education			239	239		239	86	325		23
24	Travel and Seminar							42	42		24
25	Other Admin. Staff Transportation			6,578	6,578		6,578	3,536	10,114		25
26	Insurance-Prop.Liab.Malpractice			22,565	22,565		22,565	37,202	59,767		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	14,544	3,125	450,472	468,141		468,141	(48,114)	420,027		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,241,492	236,405	837,758	2,315,655		2,315,655	(46,782)	2,268,873		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 & Rehab Ctr

#0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			630	630		630	67,210	67,840			30
31	Amortization of Pre-Op. & Org.							14,044	14,044			31
32	Interest							210,607	210,607			32
33	Real Estate Taxes							48,904	48,904			33
34	Rent-Facility & Grounds			465,858	465,858		465,858	(465,858)				34
35	Rent-Equipment & Vehicles			35,865	35,865		35,865	809	36,674			35
36	Other (specify):*											36
37	TOTAL Ownership			502,353	502,353		502,353	(124,284)	378,069			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,848		45,848		45,848		45,848			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			152,880	152,880		152,880		152,880			42
43	Other (specify):*		30	26,299	26,329		26,329	(26,329)				43
44	TOTAL Special Cost Centers		45,878	179,179	225,057		225,057	(26,329)	198,728			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,241,492	282,283	1,519,290	3,043,065		3,043,065	(197,395)	2,845,670			45

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

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	(186)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,233)	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	(59)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(28)	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	(12,085)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(942)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(24,797)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,352)		\$	30

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)	(156,043)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (156,043)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (197,395)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

Eastside Health & Rehab Ctr

ID# 0047456

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,931)	43	1
2	X-Rays-Part A	(2,712)	43	2
3	Offset Transportation Revenue	(11,312)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(247)	21	4
5	Offset Miscellaneous Nursing Supplies Revenue	(2,867)	10	5
6	Disallowed Special Events	(398)	43	6
7	Disallowed Chamber of Commerce Dues	(330)	20	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	Total	(24,797)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastside Health & Rehab Ctr# 0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	3,855	0	0	0	0	0	0	0	0	0	3,855	1
2	Food Purchase	(186)	70	0	0	0	0	0	0	0	0	0	(116)	2
3	Housekeeping	0	67	0	0	0	0	0	0	0	0	0	67	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	225	0	0	0	0	0	0	0	0	0	225	5
6	Maintenance	0	2,105	0	0	9,375	0	0	0	0	0	0	11,480	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(186)	6,322	0	0	9,375	0	0	0	0	0	0	15,511	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	(2,867)	114	0	0	0	0	0	0	0	0	0	(2,753)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(11,312)	0	0	0	0	0	0	0	0	0	0	(11,312)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(14,179)	114	0	0	0	0	0	0	0	0	0	(14,065)	16
	C. General Administration													
17	Administrative	0	(183,900)	0	0	0	0	0	0	0	0	0	(183,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,818	0	10,387	4,320	0	0	0	0	0	0	24,525	19
20	Fees, Subscriptions & Promotions	(330)	0	410	0	0	0	0	0	0	0	0	80	20
21	Clerical & General Office Expenses	(247)	0	44,942	0	376	0	0	0	0	0	0	45,071	21
22	Employee Benefits & Payroll Taxes	0	0	25,130	0	0	0	0	0	0	0	0	25,130	22
23	Inservice Training & Education	0	0	86	0	0	0	0	0	0	0	0	86	23
24	Travel and Seminar	0	0	42	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	0	0	3,536	0	0	0	0	0	0	0	0	3,536	25
26	Insurance-Prop.Liab.Malpractice	0	0	498	0	36,704	0	0	0	0	0	0	37,202	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(577)	(174,082)	74,644	10,387	41,400	0	0	0	0	0	0	(48,228)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,942)	(167,646)	74,644	10,387	50,775	0	0	0	0	0	0	(46,782)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastside Health & Rehab Ctr# 0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(59)	0	9,945	1,254	56,070	0	0	0	0	0	0	67,210	30
31	Amortization of Pre-Op. & Org.	0	0	0	2,298	11,746	0	0	0	0	0	0	14,044	31
32	Interest	(22)	0	292	15,651	194,686	0	0	0	0	0	0	210,607	32
33	Real Estate Taxes	0	0	229	0	48,675	0	0	0	0	0	0	48,904	33
34	Rent-Facility & Grounds	0	0	0	0	(465,858)	0	0	0	0	0	0	(465,858)	34
35	Rent-Equipment & Vehicles	0	0	809	0	0	0	0	0	0	0	0	809	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(81)	0	11,275	19,203	(154,681)	0	0	0	0	0	0	(124,284)	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):*	(26,329)	0	0	0	0	0	0	0	0	0	0	(26,329)	43
44	TOTAL Special Cost Centers	(26,329)	0	0	0	0	0	0	0	0	0	0	(26,329)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,352)	(167,646)	85,919	29,590	(103,906)	0	0	0	0	0	0	(197,395)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,855	\$ 3,855	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	70	70	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	67	67	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	225	225	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,105	2,105	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	114	114	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	243,900	Petersen Health Care Management, Inc.	100.00%	60,000	(183,900)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	9,818	9,818	12
13	V							13
14	Total		\$ 243,900			\$ 76,254	\$ * (167,646)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 410	\$	410	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	44,942		44,942	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,130		25,130	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	86		86	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	42		42	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,536		3,536	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	498		498	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	9,945		9,945	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	292		292	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	229		229	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	809		809	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		\$			\$ 85,919	\$ *	85,919	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 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		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%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	10,387	10,387	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		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%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,254	1,254	33
34	V	31 Amortization		Petersen Health Operations, LLC	100.00%	2,298	2,298	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	15,651	15,651	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		\$			\$ 29,590	\$ * 29,590	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	6 Maintenance	\$	Eastside Land, LLC	100.00%	\$ 9,375	\$ 9,375
16	V	19 Professional Services	\$	Eastside Land, LLC	100.00%	\$ 4,320	\$ 4,320
17	V	21 Equipment		Eastside Land, LLC	100.00%	376	376
18	V	26 Insurance-Property		Eastside Land, LLC	100.00%	3,632	3,632
19	V	26 Insurance-Mortgage Insurance		Eastside Land, LLC	100.00%	33,072	33,072
20	V	30 Depreciation		Eastside Land, LLC	100.00%	56,070	56,070
21	V	31 Amortization		Eastside Land, LLC	100.00%	11,746	11,746
22	V	32 Interest	1,215	Eastside Land, LLC	100.00%	195,901	194,686
23	V	33 Real Estate Taxes		Eastside Land, LLC	100.00%	48,675	48,675
24	V	34 Rent-Income and Grounds	465,858	Eastside Land, LLC	100.00%		(465,858)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 467,073			\$ 363,167	\$ * (103,906)

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

Facility Name & ID Number

Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eastside Health & Rehab Ctr # 0047456 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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	1,521,544	75	\$ 312,540	\$ 357,910	18,768	\$ 3,855	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	18,768	70	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	18,768	67	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	18,768	225	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	18,768	2,105	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,768	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	18,768	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	18,768	114	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	18,768	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,768	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	18,768	60,000	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	18,768	9,818	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	18,768	410	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	18,768	44,942	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	18,768	25,130	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	18,768	86	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	18,768	42	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	18,768	3,536	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	18,768	498	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	18,768	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	18,768	9,945	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	18,768	292	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	18,768	229	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	18,768	809	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 162,173	25

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

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 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

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	197,666	9	\$	\$	18,768	\$	1
2	2	Food	Resident Days	197,666	9			18,768		2
3	3	Housekeeping	Resident Days	197,666	9			18,768		3
4	4	Laundry	Resident Days	197,666	9			18,768		4
5	5	Utilities	Resident Days	197,666	9			18,768		5
6	6	Maintenance	Resident Days	197,666	9			18,768		6
7	7	Mgmt. Allocation of Benefits	Resident Days	197,666	9			18,768		7
8	10	Nursing and Medical Records	Resident Days	197,666	9			18,768		8
9	15	Mgmt. Allocation of Benefits	Resident Days	197,666	9			18,768		9
10	17	Administrative	Resident Days	197,666	9			18,768		10
11	19	Professional Services	Resident Days	197,666	9	109,392		18,768	10,387	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	197,666	9			18,768		12
13	21	Clerical and General Office	Resident Days	197,666	9			18,768		13
14	22	Employee Benefits & Payroll	Resident Days	197,666	9			18,768		14
15	23	Inservice Training & Education	Resident Days	197,666	9			18,768		15
16	24	Travel and Seminar	Resident Days	197,666	9			18,768		16
17	25	Other Admin. Staff Transport.	Resident Days	197,666	9			18,768		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	197,666	9			18,768		18
19	30	Depreciation	Resident Days	197,666	9	13,207		18,768	1,254	19
20	31	Amortization	Resident Days	197,666	9	24,205		18,768	2,298	20
21	32	Interest	Resident Days	197,666	9	164,836		18,768	15,651	21
22	33	Real Estate Taxes	Resident Days	197,666	9			18,768		22
23	34	Rent-Facility and Grounds	Resident Days	197,666	9			18,768		23
24	35	Rent-Equipment & Vehicles	Resident Days	197,666	9			18,768		24
25	TOTALS					\$ 311,640	\$		\$ 29,590	25

Facility Name & ID Number

Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Capital Finance Group		X	Mortgage	Varies	9/13/14	\$ 5,298,000	\$ 5,029,960	12/31/48	Varies	\$ 195,901	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 5,298,000	\$ 5,029,960			\$ 195,901	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(1,237)	10						
11									Home Office Allocation-PHO		15,651	11						
12									Home Office Allocation-PHCM		292	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 14,706	14						
15	TOTALS (line 9+line14)						\$ 5,298,000	\$ 5,029,960			\$ 210,607	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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 2015 report.		\$	50,112	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.)		\$	48,663	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,449)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	50,124	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	\$	229	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	48,904	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	47,478	8
	2012	49,475	9
	2013	48,176	10
	2014	48,656	11
	2015	48,663	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastside Health & Rehab Ctr COUNTY Pike

FACILITY IDPH LICENSE NUMBER 0047456

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>53-033-05</u>	<u>Long-Term Care Facility</u>	\$ <u>48,662.72</u>	\$ <u>48,662.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>48,662.72</u></u>	\$ <u><u>48,662.72</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [] NO If so, please complete the following:

1. Total Amount Incurred: 305,401 2. Number of Years Over Which it is Being Amortized: 20 3. Current Period Amortization: 14,044 4. Dates Incurred: 2013-2014

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 242,194, 2005, \$ 54,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 242,194, (blank), \$ 54,000, 3.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 441,370	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land	2005		21,000		15	1,400	1,400	14,900	9
10	Blinds	2007		7,233		10	723	723	6,869	10
11	Smoke Alarm	2007		5,580		10	558	558	5,301	11
12	Generator	2008		19,174		7			19,174	12
13	Boiler Repair	2010		3,251		7	464	464	3,016	13
14	Boiler Repair	2012		2,510		7	358	358	1,611	14
15	Boiler Repair	2012		3,025		7	432	432	1,944	15
16	Sprinkler System Replacement	2012		139,900		25	5,596	5,596	25,182	16
17	Air Conditoner-Rooftop	2012		4,989		15	332	332	1,494	17
18	Parking Lot Repair	2013		6,753		7	964	964	3,374	18
19	Furnace	2015		5,323		15	356	356	534	19
20	Tiling for Entryway	2015		2,201		7	314	314	471	20
21	Flooring for Common Area, Hallways, Offices	2015		21,945		15	1,464	1,464	2,196	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,000			(1,000)		30
31	Building Booked				38,405			(38,405)		31
32	Building Improvement Booked				10,281			(10,281)		32
33										33
34	2016-Home Office Allocation-Building Improvements			8,286			199	199		34
35	2016-Home Office Allocation-Land Improvements			762			49	49		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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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)	\$ 1,211,432	\$ 49,686		\$ 51,589	\$ 1,903	\$ 527,436	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 43,464	\$ 4,279	\$ 4,247	\$ (32)	5-10 yrs.	\$ 20,153	71
72	Current Year Purchases	14,738	2,105	1,053	(1,052)	7 yrs.	1,053	72
73	Fully Depreciated Assets	196,953					196,953	73
74	Home Office Allocation			10,951	10,951			74
75	TOTALS	\$ 255,155	\$ 6,384	\$ 16,251	\$ 9,867		\$ 218,159	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									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)	\$ 1,520,587	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,840	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,770	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 745,595	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			93
94	N/A		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.

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 29,736 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	<u>Facility</u>	<u>2006 Ford E250</u>	\$ <u>578.17</u>	\$ <u>6,938</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>578.17</u>	\$ <u>6,938</u>	21

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

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

Eastside Health & Rehab Ctr

0047456

Period Beginning 1/1/2016

Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 24,002
Dishwasher	704
Copier	4,221
Home Office Allocation	809
	<u>29,736</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>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	\$	7,860	\$ 117,895	\$	7,860	\$ 117,895	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,151	32,270		2,151	32,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,382	125,734		8,382	125,734	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				45,848		45,848	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	TOTAL			\$	18,393	\$ 275,899	\$ 45,848	18,393	\$ 321,747	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(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	\$ (510,596)	\$ (510,596)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 134,707)	891,490	891,490	3
4	Supply Inventory (priced at Cost)	8,177	8,177	4
5	Short-Term Investments			5
6	Prepaid Insurance	26,065	53,383	6
7	Other Prepaid Expenses		38,745	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 415,136	\$ 481,199	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		54,000	13
14	Buildings, at Historical Cost		967,786	14
15	Leasehold Improvements, at Historical Cost	5,878	243,646	15
16	Equipment, at Historical Cost		255,155	16
17	Accumulated Depreciation (book methods)	(630)	(745,595)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		305,401	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(26,429)	20
21	Restricted Funds		437,549	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,248	\$ 1,491,513	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 420,384	\$ 1,972,712	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 480,754	\$ 480,754	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,790	62,790	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,122	28,122	31
32	Accrued Real Estate Taxes(Sch.IX-B)		50,124	32
33	Accrued Interest Payable		16,138	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Payroll Withholdings	233,853	233,853	36
37	Accrued Management Fees	(2,172)	(2,172)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 803,347	\$ 869,609	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,029,960	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Intercompany Loans	3,803,640	(26,249)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,803,640	\$ 5,003,711	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,606,987	\$ 5,873,320	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,186,603)	\$ (3,900,608)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 420,384	\$ 1,972,712	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,582,611)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(6,990)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,589,601)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	402,998	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)	\$ 402,998	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)	\$ (4,186,603)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,069,182	1
2	Discounts and Allowances for all Levels	(231,051)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,838,131	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	485,168	6
7	Oxygen	973	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 486,141	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	186	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,561	20
21	Other Medical Services	23,343	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 107,343	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	11,312	28
28a	<u>Miscellaneous Revenue</u>	3,114	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,426	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,446,063	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	532,272	31
32	Health Care	1,315,242	32
33	General Administration	468,141	33
B. Capital Expense			
34	Ownership	502,353	34
C. Ancillary Expense			
35	Special Cost Centers	72,177	35
36	Provider Participation Fee	152,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,043,065	40
41	Income before Income Taxes (line 30 minus line 40)**	402,998	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 402,998	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,665,610	44
45	Private Pay - Net Inpatient Revenue	759,250	45
46	Medicare - Net Inpatient Revenue	276,326	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	136,945	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,838,131	49

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

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

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

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

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	2,334	2,389	\$ 61,919	\$ 25.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,022	5,399	118,650	21.98	3
4	Licensed Practical Nurses	10,475	10,905	201,471	18.48	4
5	CNAs & Orderlies	35,046	36,352	425,655	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	548	660	8,317	12.60	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	30,652	14.74	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,664	14.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,779	9,171	91,393	9.97	15
16	Dishwashers					16
17	Maintenance Workers	2,034	2,218	39,110	17.63	17
18	Housekeepers	11,870	12,148	101,111	8.32	18
19	Laundry	1,208	1,262	14,529	11.51	19
20	Administrator	2,080	2,080	60,000	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,142	1,215	14,544	11.97	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	2,080	2,080	41,508	19.96	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,080	2,080	50,728	24.39	32
33	Other(specify) <u>Transportation</u>	1,242	1,242	12,241	9.86	33
34	TOTAL (lines 1 - 33)	90,100	93,361	\$ 1,301,492 *	\$ 13.94	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	\$		35
36	Medical Director	Monthly 7,200	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,110	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	2 116	L10, C3	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)	2 \$ 11,425		49

C. CONTRACT NURSES

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

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	
Kathryn Wiswell	Administrator	0	\$ 60,000	Workers' Compensation Insurance	\$ 31,916	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	30,986	Advertising: Employee Recruitment	226	
				FICA Taxes	89,065	Health Care Worker Background Check		
				Employee Health Insurance	3,798	(Indicate # of checks performed 50)	569	
				Employee Meals		Patient Background Checks	116	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,085	
				Employee Relations	451	Miscellaneous Dues & Subscriptions	3,249	
				Employee Retirement	14	Home Office Allocation	410	
				Home Office Allocation	25,244			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 9,305		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(330)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 243,900				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 243,900				TOTAL (agree to Sch. V, line 20, col. 8)	
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
E-Data Health	Computer Services		\$ 2,941				Out-of-State Travel	\$
Cass Communications	Computer Services		853					
Honkamp Krueger & Co.	Accounting Fees		2,182	N/A			In-State Travel	
Ability Network	Computer Services		102					
Pro Title	Legal Fees		175				Seminar Expense	
Capital Finance Group	Refund of Refiance Fees		(4,320)				Home Office Allocation	42
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 1,932	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

Eastside Health & Rehab Ctr**0047456****Period Beginning****1/1/2016****Period End****12/31/2016****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		1,932
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	44
Miscellaneous	Legal	16
Miller Hall and Triggs	Legal	76
Healthcare Resources International	Legal	378
Hunziker Law	Legal	90
Lexis Nexis	Legal	8
Illinois Secretary of State	Legal	26
Lane and Waterman	Legal	155
Quinn and Johnston	Legal	686
Peoria County Recorder	Legal	19
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	393
Ginoli & Co.	Accountants	5,470
Capital Finance Group	Accountants	5,302
Miscellaneous	Computer Services	50
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3,456
Stratus Networks	Computer Services	352
Kemper Technology	Computer Services	232
AT&T	Computer Services	5
Ability Network	Computer Services	1,474
CIAN	Computer Services	176
Comcast	Computer Services	29
CCH	Computer Services	12
Charter Communications	Computer Services	34
Allscripts	Computer Services	514
ATS	Computer Services	232
Allpayer Exchange	Computer Services	12
Optimizer	Other Prof Fees	35
Ankura	Other Prof Fees	268
David Budde	Other Prof Fees	31
Bruner, Cooper, Zuck	Other Prof Fees	78
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,566
Professional Software and Services	Other Prof Fees	19
Hughes Valuation Services	Other Prof Fees	24
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)

26,457

Facility Name & ID Number Eastside Health & Rehab Ctr

0047456

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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-\$2,919
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,643 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 152,880
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. \$ 186
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 11,312
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-197,395	equal to	-197,395	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	210,607	equal to	210,607	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	48,904	equal to	48,904	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	14,044	equal to	14,044	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	67,840	equal to	67,840	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	36,674	equal to	36,674	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	275,899	equal to	275,899	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	45,848	equal to	45,848	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	532,272	equal to	532,272	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,315,242	equal to	1,315,242	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	468,141	equal to	468,141	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	502,353	equal to	502,353	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	72,177	equal to	72,177	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	152,880	equal to	152,880	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	899,931	equal to	899,931	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	20,558	equal to	20,558	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	30,652	equal to	30,652	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	121,057	equal to	121,057	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	39,110	equal to	39,110	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	101,111	equal to	101,111	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	14,529	equal to	14,529	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	60,000	equal to	60,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,544	equal to	14,544	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,301,492	equal to	1,241,492	60,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	7,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,225	< or = to	4,358	-133	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	108	-108	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	60,000	equal to	60,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	243,900	equal to	243,900	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	1,932	equal to	1,932	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	181,474	equal to	181,474	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,305	equal to	9,305	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	42	equal to	42	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	152,880	equal to	152,880	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,639	equal to	1,936	-297	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-156,043	equal to	-156,043	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	5,029,960	equal to	5,029,960	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	50,124	equal to	50,124	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	54,000	equal to	54,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,211,432	equal to	1,211,432	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	255,155	equal to	255,155	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	745,595	equal to	745,595	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-4,186,603	equal to	-4,186,603	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	402,998	equal to	402,998	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	420,384	equal to	420,384	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	121,057	12,700	0	133,757	0	133,757	3,855	137,612
2. Food Purchase	0	126,057	0	126,057	0	126,057	-116	125,941
3. Housekeeping	101,111	14,277	0	115,388	0	115,388	67	115,455
4. Laundry	14,529	3,769	0	18,298	0	18,298	0	18,298
5. Heat and Other Utilities	0	0	81,382	81,382	0	81,382	225	81,607
6. Maintenance	39,110	-59	18,339	57,390	0	57,390	11,480	68,870
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	275,807	156,744	99,721	532,272	0	532,272	15,511	547,783
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	899,931	76,508	4,358	980,797	0	980,797	-2,867	977,930
10a. Therapy	0	0	275,899	275,899	0	275,899	0	275,899
11. Activities	20,558	28	108	20,694	0	20,694	-11,312	9,382
12. Social Services	30,652	0	0	30,652	0	30,652	0	30,652
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	951,141	76,536	287,565	1,315,242	0	1,315,242	-14,179	#####
17. Administrative	0	0	243,900	243,900	0	243,900	-183,900	60,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,932	1,932	0	1,932	24,525	26,457
20. Fees, Subscriptions & Promotion	0	0	9,225	9,225	0	9,225	80	9,305
21. Clerical & General Office	14,544	3,125	9,803	27,472	0	27,472	45,071	72,543
22. Employee Benefits & Payroll	0	0	156,230	156,230	0	156,230	25,244	181,474
23. Inservice Training & Education	0	0	239	239	0	239	86	325
24. Travel and Seminar	0	0	0	0	0	0	42	42
25. Other Admin. Staff Trans	0	0	6,578	6,578	0	6,578	3,536	10,114
26. Insurance-Prop.Liab.Malpractice	0	0	22,565	22,565	0	22,565	37,202	59,767
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	14,544	3,125	450,472	468,141	0	468,141	-48,114	420,027
29. Total General Administrative	1,241,492	236,405	837,758	2,315,655	0	2,315,655	-46,782	#####
30. Depreciation	0	0	630	630	0	630	67,210	67,840
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	14,044	14,044
32. Interest	0	0	0	0	0	0	210,607	210,607
33. Real Estate	0	0	0	0	0	0	48,904	48,904
34. Rent - Facility & Grounds	0	0	465,858	465,858	0	465,858	-465,858	0
35. Rent - Equipment & Vehicles	0	0	35,865	35,865	0	35,865	809	36,674
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	502,353	502,353	0	502,353	-124,284	378,069
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	45,848	0	45,848	0	45,848	0	45,848
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	152,880	152,880	0	152,880	0	152,880
43. Other (specify):*	0	30	26,299	26,329	0	26,329	-26,329	0
44. Total Special Cost Ce	0	45,878	179,179	225,057	0	225,057	-26,329	198,728
45. Grand Total	1,241,492	282,283	1,519,290	3,043,065	0	3,043,065	-197,395	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-510,596	-510,596
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	891,490	891,490
4. Supply Inventory	8,177	8,177
5. Short-Term Investments	0	0
6. Prepaid Insurance	26,065	53,383
7. Other Prepaid Expenses	0	38,745
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	415,136	481,199
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	54,000
14. Buildings, at Historical Cost	0	967,786
15. Leasehold Improvements, Historical Cost	5,878	243,646
16. Equipment, at Historical Cost	0	255,155
17. Accumulated Depreciation (book methods)	-630	-745,595
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	305,401
20. Accum Amort - Org/Pre-Op Costs	0	-26,429
21. Restricted Funds	0	437,549
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	5,248	1,491,513
25. Total Assets	420,384	1,972,712
CURRENT LIABILITIES		
26. Accounts Payable	480,754	480,754
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	62,790	62,790
31. Accrued Taxes Payable	28,122	28,122
32. Accrued Real Estate Taxes	0	50,124
33. Accrued Interest Payable	0	16,138
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	233,853	233,853
37. Other Current Liabilities (specify):	-2,172	-2,172
38. Total Current Liabilities	803,347	869,609
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	5,029,960
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	3,803,640	-26,249
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,803,640	5,003,711
46. Total Liabilities	4,606,987	5,873,320
47. Total Equity	#####	-3,900,608
48. Total Liabilities and Equity	420,384	1,972,712

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,069,182
2. Discounts and Allowances for all Levels	-231,051
Subtotal - Inpatient Care	2,838,131
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	485,168
7. Oxygen	973
Subtotal - Ancillary Revenue	486,141
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	186
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	77,253
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	6,561
21. Other Medical Services	23,343
22. Laundry	0
Subtotal - Other Operating Revenue	107,343
24. Contributions	0
25. Interest and Other Investments Income	22
Subtotal - Non-Operating Revenue	22
27. Other Revenue (specify):	11,312
28. Other Revenue (specify):	3,114
Subtotal - Other Revenue	14,426
30. Total Revenue	3,446,063
31. General Services	561,468
32. Health Care	1,436,234
33. General Administration	496,870
34. Ownership	507,601
35. Special Cost Centers	324,352
35. Provider Participation Fee	162,894
37. Other	0
40. Total Expenses	3,489,419
41. Income Before Income Taxes	-43,356
42. Income Taxes	0
43. Net Income or Loss for the Year	-43,356