

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0047456</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Eastside Health & Rehabilitation Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>1400 East Washington Street</u> <u>Pittsfield</u> <u>62363</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Pike</u>																																																			
Telephone Number: <u>(217) 285-4491</u> Fax # <u>(217) 385-4242</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>10/01/2005</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☒	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____			
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		☐	Trust	_____																																															
		☐	Other _____	_____																																															
In the event there are further questions about this report, please contact:																																																			
Name: <u>Mike Kocher</u>																																																			
Telephone Number: <u>(309) 689-5850</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Mark B. Petersen</u>																																																	
		(Title) <u>Chief Executive Officer</u>																																																	
		Paid Preparer																																																	
		(Signed) _____ (Date) _____																																																	
		(Print Name and Title) _____																																																	
		(Firm Name & Address) _____																																																	
		(Telephone) <u>()</u> Fax # <u>()</u>																																																	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

Facility Name & ID Number Eastside Health & Rehabilitation Center# 0047456 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 bedsN/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	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	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	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,562</u>	<u>4,903</u>	<u>3,037</u>	<u>22,502</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,562</u>	<u>4,903</u>	<u>3,037</u>	<u>22,502</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.01%

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?

YesG. 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

2,664Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	117,323	14,837		132,160		132,160	4,097	136,257		1
2	Food Purchase		121,077		121,077		121,077	(286)	120,791		2
3	Housekeeping	88,670	14,731		103,401		103,401	32	103,433		3
4	Laundry		7,354		7,354		7,354	6	7,360		4
5	Heat and Other Utilities			57,281	57,281		57,281	323	57,604		5
6	Maintenance	51,823	7,222	20,357	79,402		79,402	2,272	81,674		6
7	Other (specify):* Home Off. Ben. All.							546	546		7
8	TOTAL General Services	257,816	165,221	77,638	500,675		500,675	6,990	507,665		8
	B. Health Care and Programs										
9	Medical Director			6,850	6,850		6,850		6,850		9
10	Nursing and Medical Records	915,749	64,281	3,874	983,904		983,904	39	983,943		10
10a	Therapy		27	361,533	361,560		361,560		361,560		10a
11	Activities	33,572	27	65	33,664		33,664	(5,538)	28,126		11
12	Social Services	27,234			27,234		27,234		27,234		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	976,555	64,335	372,322	1,413,212		1,413,212	(5,499)	1,407,713		16
	C. General Administration										
17	Administrative			269,000	269,000		269,000	(202,300)	66,700		17
18	Directors Fees										18
19	Professional Services			2,879	2,879		2,879	95,766	98,645		19
20	Dues, Fees, Subscriptions & Promotions			4,846	4,846		4,846	364	5,210		20
21	Clerical & General Office Expenses	8,568	3,540	16,612	28,720		28,720	47,423	76,143		21
22	Employee Benefits & Payroll Taxes			177,926	177,926		177,926		177,926		22
23	Inservice Training & Education							77	77		23
24	Travel and Seminar							8	8		24
25	Other Admin. Staff Transportation			7,078	7,078		7,078	5,360	12,438		25
26	Insurance-Prop.Liab.Malpractice			29,251	29,251		29,251	876	30,127		26
27	Other (specify):* Home Off. Ben. All.							10,939	10,939		27
28	TOTAL General Administration	8,568	3,540	507,592	519,700		519,700	(41,487)	478,213		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,242,939	233,096	957,552	2,433,587		2,433,587	(39,996)	2,393,591		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			68,676	68,676		68,676	(4,254)	64,422			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,133	29,133		29,133	62,356	91,489			32
33	Real Estate Taxes			47,383	47,383		47,383	580	47,963			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,651	46,651		46,651	640	47,291			35
36	Other (specify):*											36
37	TOTAL Ownership			191,843	191,843		191,843	59,322	251,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,079		112,079		112,079		112,079			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			241,343	241,343		241,343		241,343			42
43	Other (specify):* Non-allowable Costs		233	25,968	26,201		26,201	(26,201)				43
44	TOTAL Special Cost Centers		112,312	267,311	379,623		379,623	(26,201)	353,422			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,242,939	345,408	1,416,706	3,005,053		3,005,053	(6,875)	2,998,178			45

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

		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	(424)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,267)	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	(8,288)	30		9
10	Interest and Other Investment Income	(786)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	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	(12,050)	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	(6,516)	43		24
25	Fund Raising, Advertising and Promotional	(1,069)	43		25
	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	(8,997)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,432)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	34,557	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,557		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,875)		37

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

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

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

STATE OF ILLINOIS
Eastside Health & Rehabilitation Center

Report Period Beginning: ID# 0047456
Ending: 1/1/2012
12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Labs-Part A	\$ (3,115)	43	1
2	X-Rays-Part A	(129)	43	2
3	Offset Transportation Revenue	(5,538)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(195)	21	4
5	Disallow Special Events	(20)	43	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
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21				21
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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	(8,997)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	4,097	0	0	0	0	0	0	0	0	0	4,097	1
2	Food Purchase	(424)	138	0	0	0	0	0	0	0	0	0	(286)	2
3	Housekeeping	0	32	0	0	0	0	0	0	0	0	0	32	3
4	Laundry	0	6	0	0	0	0	0	0	0	0	0	6	4
5	Heat and Other Utilities	0	323	0	0	0	0	0	0	0	0	0	323	5
6	Maintenance	0	2,272	0	0	0	0	0	0	0	0	0	2,272	6
7	Other (specify):*	0	546	0	0	0	0	0	0	0	0	0	546	7
8	TOTAL General Services	(424)	7,414	0	0	0	0	0	0	0	0	0	6,990	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	0	39	0	0	0	0	0	0	0	0	0	39	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,538)	0	0	0	0	0	0	0	0	0	0	(5,538)	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	(5,538)	39	0	0	0	0	0	0	0	0	0	(5,499)	16
	C. General Administration													
17	Administrative	0	(202,300)	0	0	0	0	0	0	0	0	0	(202,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,127	0	73,639	0	0	0	0	0	0	0	95,766	19
20	Fees, Subscriptions & Promotions	0	0	315	49	0	0	0	0	0	0	0	364	20
21	Clerical & General Office Expenses	(195)	0	46,369	1,249	0	0	0	0	0	0	0	47,423	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	77	0	0	0	0	0	0	0	0	77	23
24	Travel and Seminar	0	0	8	0	0	0	0	0	0	0	0	8	24
25	Other Admin. Staff Transportation	0	0	5,313	47	0	0	0	0	0	0	0	5,360	25
26	Insurance-Prop.Liab.Malpractice	0	0	876	0	0	0	0	0	0	0	0	876	26
27	Other (specify):*	0	0	10,939	0	0	0	0	0	0	0	0	10,939	27
28	TOTAL General Administration	(195)	(180,173)	63,897	74,984	0	0	0	0	0	0	0	(41,487)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,157)	(172,720)	63,897	74,984	0	0	0	0	0	0	0	(39,996)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(8,288)	0	3,936	98	0	0	0	0	0	0	0	(4,254)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(786)	0	7,825	55,317	0	0	0	0	0	0	0	62,356	32
33	Real Estate Taxes	0	0	580	0	0	0	0	0	0	0	0	580	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	577	63	0	0	0	0	0	0	0	640	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,074)	0	12,918	55,478	0	0	0	0	0	0	0	59,322	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):*	(26,201)	0	0	0	0	0	0	0	0	0	0	(26,201)	43
44	TOTAL Special Cost Centers	(26,201)	0	0	0	0	0	0	0	0	0	0	(26,201)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(41,432)	(172,720)	76,815	130,462	0	0	0	0	0	0	0	(6,875)	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,097	\$ 4,097	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	138	138	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	6	6	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	323	323	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,272	2,272	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	546	546	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	39	39	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	269,000	Petersen Health Care, Inc.	100.00%	66,700	(202,300)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	22,127	22,127	12
13	V								13
14	Total			\$ 269,000			\$ 96,280	\$ * (172,720)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 315	\$ 315	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	46,369	46,369	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	77	77	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	8	8	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	5,313	5,313	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	876	876	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,939	10,939	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,936	3,936	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,825	7,825	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	580	580	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	577	577	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		\$			\$ 76,815	\$ * 76,815	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	\$		100.00%	\$ 0	\$	15
16	V	2	Food			100.00%	0		16
17	V	3	Housekeeping			100.00%	0		17
18	V	4	Laundry			100.00%	0		18
19	V	5	Utilities			100.00%	0		19
20	V	6	Maintenance			100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits			100.00%	0		21
22	V	10	Nursing and Medical Records			100.00%	0		22
23	V	12	Social Services			100.00%	0		23
24	V	17	Administrative			100.00%	0		24
25	V	19	Professional Services			100.00%	73,639	73,639	25
26	V	20	Dues, Fees, Subs & Promotions			100.00%	49	49	26
27	V	21	Clerical and General Office			100.00%	1,249	1,249	27
28	V	22	Employee Benefits & Payroll			100.00%	0		28
29	V	23	Inservice Training & Education			100.00%	0		29
30	V	24	Travel and Seminar			100.00%	0		30
31	V	25	Other Admin. Staff Transport.			100.00%	47	47	31
32	V	26	Insurance-Prop./Liab./Malprac.			100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits			100.00%	0		33
34	V	30	Depreciation			100.00%	98	98	34
35	V	32	Interest			100.00%	55,317	55,317	35
36	V	33	Real Estate Taxes			100.00%	0		36
37	V	34	Rent-Facility and Grounds			100.00%	0		37
38	V	35	Rent-Equipment & Vehicles			100.00%	63	63	38
39	Total			\$			\$ 130,462	\$ * 130,462	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: 1/1/2012 Ending: 12/31/2012

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 Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				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 & Rehabilitation Center

0047456

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eastside Health & Rehabilitation Center # 0047456 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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											3
4	N/A										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

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	1,569,393	74	\$ 285,707	\$ 284,214	22,502	\$ 4,097	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	22,502	138	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	22,502	32	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	22,502	6	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	22,502	323	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	22,502	2,272	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	22,502	546	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	22,502	39	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	22,502	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	22,502	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	22,502	66,700	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	22,502	22,127	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	22,502	315	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	22,502	46,369	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	22,502	77	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	22,502	8	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	22,502	5,313	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	22,502	876	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	22,502	10,939	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	22,502	3,936	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	22,502	7,825	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	22,502	580	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	22,502	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	22,502	577	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 173,095	25

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

Report Period Beginning:

1/1/2012Ending: 2/31/2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	404,785	21	\$	\$	22,502	\$	1
2	2	Food	Resident Days	404,785	21			22,502		2
3	3	Housekeeping	Resident Days	404,785	21			22,502		3
4	4	Laundry	Resident Days	404,785	21			22,502		4
5	5	Utilities	Resident Days	404,785	21			22,502		5
6	6	Maintenance	Resident Days	404,785	21			22,502		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21			22,502		7
8	10	Nursing and Medical Records	Resident Days	404,785	21			22,502		8
9	12	Social Services	Resident Days	404,785	21			22,502		9
10	17	Administrative	Resident Days	404,785	21			22,502		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676		22,502	73,639	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876		22,502	49	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478		22,502	1,249	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21			22,502		14
15	23	Inservice Training & Education	Resident Days	404,785	21			22,502		15
16	24	Travel and Seminar	Resident Days	404,785	21			22,502		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849		22,502	47	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21			22,502		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21			22,502		19
20	30	Depreciation	Resident Days	404,785	21	1,761		22,502	98	20
21	32	Interest	Resident Days	404,785	21	995,096		22,502	55,317	21
22	33	Real Estate Taxes	Resident Days	404,785	21			22,502		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21			22,502		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130		22,502	63	24
25	TOTALS					\$ 2,346,866	\$		\$ 130,462	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 375,000	\$ 349,801	12/31/13	Varies	\$ 29,133	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 375,000	\$ 349,801				\$ 29,133	9						
	B. Non-Facility Related*																		
10												10							
11								Interest Income Offset			(786)	11							
12								Home Office Allocation-PHC			7,825	12							
13								Home Office Allocation-PHO			55,317	13							
14	TOTAL Non-Facility Related						\$	\$				\$ 62,356	14						
15	TOTALS (line 9+line14)						\$ 375,000	\$ 349,801				\$ 91,489	15						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	49,140	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.)		2011	\$	47,478	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,662)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	49,045	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.				580	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	47,963	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	75,509	8	
		2008	48,411	9	
		2009	47,847	10	
		2010	47,697	11	
		2011	47,478	12	
Accrual based on prior year tax bill.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

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

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	53-033-05	Long-Term Care Facility	\$ 47,477.84	\$ 47,477.84
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 47,477.84	\$ 47,477.84

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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? (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? YES NO (X)
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	242,194	2005	\$ 54,000	1
2					2
3	TOTALS	242,194		\$ 54,000	3

Facility Name & ID Number Eastside Health & Rehabilitation Center

0047456

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2005	1970	\$ 959,500	\$	25	\$ 38,380	\$ 38,380	\$ 287,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land		2005		21,000		15	1,400	1,400	9,300	9
10	Blinds		2007		7,233		10	723	723	3,977	10
11	Smoke Alarm		2007		5,580		10	558	558	3,069	11
12	Generator		2008		19,174		7	2,739	2,739	12,327	12
13	Boiler Repair		2010		3,251		7	464	464	1,160	13
14	Boiler Repair		2012		2,510		7	179	179	179	14
15	Boiler Repair		2012		3,025		7	216	216	216	15
16	Sprinkler System Replacement		2012		139,900		25	2,798	2,798	2,798	16
17	Air Conditoner-Rooftop		2012		4,989		15	166	166	166	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	Land Improvements Booked					1,000			(1,000)		30
31	Building Booked					38,405			(38,405)		31
32	Building Improvement Booked					7,856			(7,856)		32
33											33
34	2012-Home Office Allocation-Building Improvements				10,524			252	252		34
35	2012-Home Office Allocation-Land Improvements				982			63	63		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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									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)		\$ 1,177,668	\$ 47,261		\$ 47,938	\$ 677	\$ 321,042	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	\$203,144	\$21,317	\$12,765	\$ (8,552)	5-10 yrs.	\$196,095	71
72	Current Year Purchases	2,751	98		(98)			72
73	Fully Depreciated Assets	5,993					5,993	73
74	Home Office Allocation			3,719	3,719			74
75	TOTALS	\$211,888	\$21,415	\$16,484	\$ (4,931)		\$202,088	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	2	
	Reference	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)	\$1,443,55681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$68,67682
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$64,42283**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(4,254)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$523,13085

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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: \$ 40,353
- 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	Facility	2006 Ford E250	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	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. /2013 \$
13. /2014 \$
14. /2015 \$

* 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 1/1/2012
Period End 12/31/2012

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$ 34,170
Dishwasher	732
Laundry Equipment	4,811
Copier	-
Home Office Allocation	640
	<u>40,353</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	9,837	\$ 147,552	\$	9,837	\$ 147,552	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,250	18,749		1,250	18,749	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		12,993	194,902	27	12,993	194,929	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				112,079		112,079	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			22	330		22	330	13
14	TOTAL			\$	24,102	\$ 361,533	\$ 112,106	24,102	\$ 473,639	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,970,467	\$ 2,970,467	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,000)	804,811	804,811	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,207	29,207	6
7	Other Prepaid Expenses	8,177	8,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,812,662	\$ 3,812,662	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	69,000	54,000	13
14	Buildings, at Historical Cost	959,500	970,024	14
15	Leasehold Improvements, at Historical Cost	180,081	207,644	15
16	Equipment, at Historical Cost	217,467	211,888	16
17	Accumulated Depreciation (book methods)	(517,587)	(523,130)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 908,461	\$ 920,426	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,721,123	\$ 4,733,088	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 789,817	\$ 789,817	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,811	23,811	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,455	17,455	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,045	49,045	32
33	Accrued Interest Payable	968	968	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	17,807	17,807	36
37	<u>Accrued Management Fees</u>	140,125	140,125	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,039,028	\$ 1,039,028	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	349,801	349,801	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 349,801	\$ 349,801	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,388,829	\$ 1,388,829	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,332,294	\$ 3,344,259	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,721,123	\$ 4,733,088	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,453,662	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,453,662	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	878,632	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)	\$ 878,632	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)	\$ 3,332,294	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastside Health & Rehabilitation Center# 0047456Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,402,848	1
2	Discounts and Allowances for all Levels	(291,360)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,111,488	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	567,015	6
7	Oxygen	940	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 567,955	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	424	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,146	20
21	Other Medical Services	17,581	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 197,723	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	786	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 786	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	195	28
28a	Transportation Revenue	5,538	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,733	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,883,685	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	500,675	31
32	Health Care	1,413,212	32
33	General Administration	519,700	33
	B. Capital Expense		
34	Ownership	191,843	34
	C. Ancillary Expense		
35	Special Cost Centers	138,280	35
36	Provider Participation Fee	241,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,005,053	40
41	Income before Income Taxes (line 30 minus line 40)**	878,632	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 878,632	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,800,293	44
45	Private Pay - Net Inpatient Revenue	691,455	45
46	Medicare - Net Inpatient Revenue	623,532	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(1,591)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(2,201)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,111,488	49

* 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.

*** 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.

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	2,019	2,019	\$ 54,673	\$ 27.08	1
2	Assistant Director of Nursing	2,080	2,080	37,156	17.86	2
3	Registered Nurses	4,110	4,317	88,971	20.61	3
4	Licensed Practical Nurses	13,743	14,289	242,792	16.99	4
5	CNAs & Orderlies	39,276	41,103	446,198	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,784	1,939	21,622	11.15	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	27,234	13.09	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,051	25,592	12.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,882	10,365	91,731	8.85	15
16	Dishwashers					16
17	Maintenance Workers	3,538	3,737	51,823	13.87	17
18	Housekeepers	9,898	10,292	88,670	8.62	18
19	Laundry					19
20	Administrator	2,080	2,080	66,700	32.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	786	786	8,568	10.90	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Care Plan Coord	2,080	2,080	45,959	22.10	32
33	Other(specify) Transportation	1,107	1,107	11,950	10.79	33
34	TOTAL (lines 1 - 33)	96,410	100,325	\$ 1,309,639 *	\$ 13.05	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	6,850	L9, C3	36
37	Medical Records Consultant	7	174	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,410	L10, C3	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)	7	\$ 11,434		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount		
Jerri Springer	Administrator	0	\$ 66,700		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,700		
B. Administrative - Other					
Description			Amount		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 269,000		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 269,000		
C. Professional Services					
Vendor/Payee	Type		Amount		
E-Data Health	Computer Services		\$ 1,460		
Frontier	Computer Services		1,299		
Honkamp Krueger & Co.	Accounting Fees		120		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,879		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 35,821		
Unemployment Compensation Insurance			35,313		
FICA Taxes			95,765		
Employee Health Insurance			10,329		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Employee Relations			351		
Employee Retirement			347		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 177,926		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description	Line #		Amount		
N/A					
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$ 3,980		
Advertising: Employee Recruitment					
Health Care Worker Background Check (Indicate # of checks performed)					
Patient Background Checks	45		458		
Miscellaneous Licenses & Permits			408		
Home Office Allocation			364		
Less: Public Relations Expense		()			
Non-allowable advertising		()			
Yellow page advertising		()			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,210		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense					
Home Office Allocation			8		
Entertainment Expense		()			
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 8		

*** Attach copy of IMRF notifications**

****See instructions.**

Eastside Health & Rehabilitation Center
0047456
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,879
Home Office Allocation		
Sorling Northrup	Legal	70
Ginoli & Company	Accountants	2,518
Miscellaneous	Computer Services	61
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	3,419
Access 2 Go	Computer Services	144
Stratus Networks	Computer Services	142
Kemper Technology	Computer Services	233
CCH	Computer Services	12
Medifax	Computer Services	27
Vision Share/Ability Network	Computer Services	261
Barracuda	Computer Services	9
CIAN	Computer Services	71
Comcast	Computer Services	22
Postini	Computer Services	221
Optimizer Systems	Other Prof Fees	35
Marotta Gund Budd & Dzera	Other Prof Fees	87,697
David Budde	Other Prof Fees	13
Courtney Bourban	Other Prof Fees	195
All Scripts	Other Prof Fees	597
Heritage Enterprises	Other Prof Fees	14
Miscellaneous Vendors	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		98,645

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,014 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 241,343
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. \$ 424
- (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. \$ 5,538
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Template

10:49 AM

6/13/2013

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	-6,875	equal to	-6,875	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	91,489	equal to	91,489	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	47,963	equal to	47,963	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,422	equal to	64,422	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	47,291	equal to	47,291	0	O.K.	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		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	361,560	equal to	361,560	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	112,106	equal to	112,106	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	500,675	equal to	500,675	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,413,212	equal to	1,413,212	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	519,700	equal to	519,700	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	191,843	equal to	191,843	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	138,280	equal to	138,280	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4
Income Stat. Prov. Partic.	241,343	equal to	241,343	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	915,749	equal to	915,749	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	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	33,572	equal to	33,572	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	27,234	equal to	27,234	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	117,323	equal to	117,323	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	51,823	equal to	51,823	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	88,670	equal to	88,670	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	66,700	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	8,568	equal to	8,568	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,309,639	equal to	1,242,939	66,700	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,850	< or = to	6,850	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,584	< or = to	3,874	710	FAILED	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	65	-65	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	66,700	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	269,000	equal to	269,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	2,879	equal to	2,879	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	177,926	equal to	177,926	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,210	equal to	5,210	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	8	equal to	8	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	241,343	equal to	241,343	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
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	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,664	equal to	3,037	-373	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	34,557	equal to	34,557	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	349,801	equal to	349,801	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	49,045	equal to	49,045	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	1,177,668	equal to	1,177,668	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	211,888	equal to	211,888	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	523,130	equal to	523,130	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,332,294	equal to	3,332,294	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	878,632	equal to	878,632	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..5	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,721,123	equal to	4,721,123	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	117,323	14,837	0	132,160	0	132,160	4,097	136,257
2. Food Purchase	0	121,077	0	121,077	0	121,077	-286	120,791
3. Housekeeping	88,670	14,731	0	103,401	0	103,401	32	103,433
4. Laundry	0	7,354	0	7,354	0	7,354	6	7,360
5. Heat and Other Utilities	0	0	57,281	57,281	0	57,281	323	57,604
6. Maintenance	51,823	7,222	20,357	79,402	0	79,402	2,272	81,674
7. Other (specify)*	0	0	0	0	0	0	546	546
8. Total General Services	257,816	165,221	77,638	500,675	0	500,675	6,990	507,665
9. Medical Director	0	0	6,850	6,850	0	6,850	0	6,850
10. Nursing & Medical Records	915,749	64,281	3,874	983,904	0	983,904	39	983,943
10a. Therapy	0	27	361,533	361,560	0	361,560	0	361,560
11. Activities	33,572	27	65	33,664	0	33,664	-5,538	28,126
12. Social Services	27,234	0	0	27,234	0	27,234	0	27,234
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	976,555	64,335	372,322	1,413,212	0	1,413,212	-5,499	1,407,713
17. Administrative	0	0	269,000	269,000	0	269,000	-202,300	66,700
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,879	2,879	0	2,879	95,766	98,645
20. Fees, Subscriptions & Promotion	0	0	4,846	4,846	0	4,846	364	5,210
21. Clerical & General Office	8,568	3,540	16,612	28,720	0	28,720	47,423	76,143
22. Employee Benefits & Payroll	0	0	177,926	177,926	0	177,926	0	177,926
23. Inservice Training & Education	0	0	0	0	0	0	77	77
24. Travel and Seminar	0	0	0	0	0	0	8	8
25. Other Admin. Staff Trans	0	0	7,078	7,078	0	7,078	5,360	12,438
26. Insurance-Prop.Liab.Malpractice	0	0	29,251	29,251	0	29,251	876	30,127
27. Other (specify)*	0	0	0	0	0	0	10,939	10,939
28. Total General Adminis	8,568	3,540	507,592	519,700	0	519,700	-41,487	478,213
29. Total General Administrative	1,242,939	233,096	957,552	2,433,587	0	2,433,587	-39,996	2,393,591
30. Depreciation	0	0	68,676	68,676	0	68,676	-4,254	64,422
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	29,133	29,133	0	29,133	62,356	91,489
33. Real Estate	0	0	47,383	47,383	0	47,383	580	47,963

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	46,651	46,651	0	46,651	640	47,291
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	191,843	191,843	0	191,843	59,322	251,165
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	112,079	0	112,079	0	112,079	0	112,079
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	241,343	241,343	0	241,343	0	241,343
43. Other (specify):*	0	233	25,968	26,201	0	26,201	-26,201	0
44. Total Special Cost Ce	0	112,312	267,311	379,623	0	379,623	-26,201	353,422
45. Grand Total	1,242,939	345,408	1,416,706	3,005,053	0	3,005,053	-6,875	2,998,178

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,970,467	2,970,467
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	804,811	804,811
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	29,207	29,207
7. Other Prepaid Expenses	8,177	8,177
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	3,812,662	3,812,662
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	69,000	54,000
14. Buildings, at Historical Cost	959,500	970,024
15. Leasehold Improvements, Historical Cost	180,081	207,644
16. Equipment, at Historical Cost	217,467	211,888
17. Accumulated Depreciation (book methods)	-517,587	-523,130
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	908,461	920,426
25. Total Assets	4,721,123	4,733,088
CURRENT LIABILITIES		
26. Accounts Payable	789,817	789,817
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	23,811	23,811
31. Accrued Taxes Payable	17,455	17,455
32. Accrued Real Estate Taxes	49,045	49,045
33. Accrued Interest Payable	968	968
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	17,807	17,807

37. Other Current Liabilities (specify):	140,125	140,125
38. Total Current Liabilities	1,039,028	1,039,028
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	349,801	349,801
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	349,801	349,801
46.Total Liabilities	1,388,829	1,388,829
47.Total Equity	3,332,294	3,344,259
48.Total Liabilities and Equity	4,721,123	4,733,088

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,402,848
2. Discounts and Allowances for all Levels	-291,360
Subtotal - Inpatient Care	3,111,488
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	567,015
7. Oxygen	940
Subtotal - Anciliary Revenue	567,955
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	424
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	169,572
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	10,146
21. Other Medical Services	17,581
22. Laundry	0
Subtotal - Other Operating Revenue	197,723
24. Contributions	0
25. Interest and Other Investments Income	786
Subtotal - Non-Operating Revenue	786
27. Other Revenue (specify):	0
28. Other Revenue (specify):	5,733
Subtotal - Other Revenue	5,733
30. Total Revenue	3,883,685
31. General Services	500,675
32. Health Care	1,413,212
33. General Administration	519,700
34. Ownership	191,843

35. Special Cost Centers	138,280
35. Provider Participation Fee	241,343
37. Other	0
40. Total Expenses	3,005,053
41. Income Before Income Taxes	878,632
42. Income Taxes	0
43. Net Income or Loss for the Year	878,632

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 224 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is
equal to or above 93 percent, divide your total updated
support costs (Step II, C, 3, above) by the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent
of the licensed bed days (Cost Report, Page 2, Schedule III-A,
Column 4, Line 7). Then subtract the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5,
Line 14) from the result and calculate one-third of the
difference. Then add the one-third difference to the total
patient days to obtain your adjusted occupancy. Next
divide your total updated Support Costs (Step II, C, 3 above)
by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

Table I
Inflation Multipliers

	Base Number	General Services Multiplier	General Administration Multiplier
	261	1.1187	1.1531
	262	1.1182	1.1530
	263	1.1178	1.1528
	264	1.1071	1.1376
	265	1.1067	1.1375
	266	1.1062	1.1373
	267	1.0975	1.1249
	268	1.0971	1.1248
	269	1.0966	1.1246
	270	1.0887	1.1134
	271	1.0882	1.1132
	272	1.0877	1.1130
	273	1.0815	1.1043
	274	1.0811	1.1042
	275	1.0806	1.1040
	276	1.0730	1.0932
	277	1.0725	1.0931
	278	1.0720	1.0929
	279	1.0666	1.0853
	280	1.0661	1.0851
	281	1.0657	1.0850
	282	1.0588	1.0753
	283	1.0583	1.0751
	284	1.0579	1.0750
	285	1.0535	1.0690
	286	1.0531	1.0689
	287	1.0527	1.0687
	288	1.0413	1.0524
	289	1.0409	1.0522
	290	1.0404	1.0521
	291	1.0321	1.0403
	292	1.0317	1.0402
	293	1.0313	1.0400
	294	1.0254	1.0318
	295	1.0250	1.0317
	296	1.0246	1.0315
	297	1.0228	1.0294
	298	1.0224	1.0293
	299	1.0219	1.0291
	300	1.0166	1.0218
	301	1.0162	1.0216
	302	1.0158	1.0215
	303	1.0076	1.0098
	304	1.0072	1.0097
	305	1.0067	1.0095
	306	1.0000	1.0000

\$257,816
\$1,242,939
20.7424%
\$177,926
\$36,906
\$507,665
\$544,571

\$8,568
\$1,242,939
0.6893%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$177,926
\$1,226
\$478,213
\$177,926
\$301,513

6.5
0.526315789
1344
1351.026316
907.00
444

1
1

\$544,571
1

\$544,571

\$301,513
<u>1</u>
\$301,513
<u>\$846,084</u>

\$33.30

\$846,084
<u>22,502</u>
<u>\$37.60</u>

33,580
<u>0.93</u>
31,229
<u>22,502</u>
8,727
2,909
<u>22,502</u>
<u>25,411</u>

\$846,084

25411

\$33.30

\$41.84

\$33.30

\$8.54

0.5

\$4.27

\$33.30

37.57

\$41.84

\$33.30

\$8.54

0.5
<u>\$4.27</u>
3.635
\$3.635
<u>\$33.30</u>
<u>\$36.94</u>
<u>\$36.94</u>
\$41.84
\$34.67

7/DD 16 Facilities)
centiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655