

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0047456</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Eastside Health Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2025</u> to <u>12/31/2025</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>1400 E Washington St</u> <u>Pittsfield</u> <u>62363</u> Number City Zip Code																											
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>10/1/2005</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</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	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
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	☒ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberEastside Health Rehab Center# 0047456Report Period Beginning: 01/01/2025Ending: 12/31/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF	5,802	6,666	1,764		2,402	1,826	1,388	19,848	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,802	6,666	1,764		2,402	1,826	1,388	19,848	14

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

59.11%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO X

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 X Date 10/1/2005 NO

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

YES X NO If YES, enter certified beds.

number of certified beds 92

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES X NO

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

* 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	186,850	20,284	56,524	263,658		263,658		263,658		1
2	Food Purchase		154,120		154,120		154,120	(404)	153,716		2
3	Housekeeping	143,618	9,530		153,148		153,148		153,148		3
4	Laundry		8,394		8,394		8,394		8,394		4
5	Heat and Other Utilities			90,193	90,193		90,193		90,193		5
6	Maintenance	57,430	20,263	54,869	132,562		132,562		132,562		6
7	Other (specify):*										7
8	TOTAL General Services	387,898	212,591	201,586	802,075		802,075	(404)	801,671		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,801,960	19,240	23,454	1,844,654		1,844,654		1,844,654		10
10a	Therapy										10a
11	Activities	62,424	2,563		64,987		64,987	260	65,247		11
12	Social Services	47,480			47,480		47,480		47,480		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,911,864	21,803	39,054	1,972,721		1,972,721	260	1,972,981		16
	C. General Administration										
17	Administrative	84,888		282,979	367,867		367,867		367,867		17
18	Directors Fees										18
19	Professional Services			135,932	135,932		135,932		135,932		19
20	Dues, Fees, Subscriptions & Promotions			11,922	11,922		11,922		11,922		20
21	Clerical & General Office Expenses	45,273	16,012	1,315,490	1,376,775		1,376,775	(970,384)	406,391		21
22	Employee Benefits & Payroll Taxes			246,837	246,837		246,837		246,837		22
23	Inservice Training & Education			110	110		110		110		23
24	Travel and Seminar			6,683	6,683		6,683		6,683		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			151,358	151,358		151,358		151,358		26
27	Other (specify):*										27
28	TOTAL General Administration	130,161	16,012	2,151,311	2,297,484		2,297,484	(970,384)	1,327,100		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,429,923	250,406	2,391,951	5,072,280		5,072,280	(970,528)	4,101,752		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			1,072	1,072		1,072		1,072		30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes			50,049	50,049		50,049		50,049		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			23,353	23,353		23,353		23,353		35
36	Other (specify):*										36
37	TOTAL Ownership			74,474	74,474		74,474		74,474		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		177,168	240,732	417,900		417,900		417,900		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			317,510	317,510		317,510		317,510		42
43	Other (specify):* Marketing	6,500		18,602	25,102		25,102	(25,102)			43
44	TOTAL Special Cost Centers	6,500	177,168	576,844	760,512		760,512	(25,102)	735,410		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,436,423	427,574	3,043,269	5,907,266		5,907,266	(995,630)	4,911,636		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	(404)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment				19
20	Contributions	(103)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,004,614)	21		24
25	Fund Raising, Advertising and Promotional	(18,602)	43		25
26	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	28,093			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (995,630)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (995,630)		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

Report Period Beginning:

Ending:

ID#

0047456

01/01/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Marketing Wages	(6,500)	43	3
4	Misc Income	34,333	21	4
5	Transportation Income	260	11	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	28,093		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		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	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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: 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		
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

Report Period Beginning:

Ending:

ID#

0047456

01/01/2025

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name		M.I.	Last Name		Place of Residence		Operator/Licensee	Building Co.	Management	
						City	State	Ownership Percentage	Ownership Percentage	Co./Home Office Ownership Percentage	
1	Mark		B	Petersen		Peoria	IL	100.00000			1
2											2
3											3
4											4
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75											75

VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Aleso Health Care Center	Aledo	Mason Point	Sullivan	Peterson Companies	Peoria	1	
2	Arcola Health Care Center	Arcola	McLeansborr Rehab & Health Care Center	McLeansboro	Petersen Health Care	Peoria	2	
3	Aspen Rehab & Health Center	Silvis	Mt Vernon Health Care Center	Mt. Vernon	Peterson Health Care	Peoria	3	
4	Batavia Rehab & Health Care Center	Batavia	Newman Rehab & Health Care Center	Newman	Peterson Health Oper	Peoria	4	
5	Bement Health Care Center	Bement	Nokomis Rehab & Health Care center	Nokomis	Perterson Health Syst	Peoria	5	
6	Benton Rehab & Health Care Center	Benton	North Aurora Care Center	North Aurora	Petersen Hotels, LLC	Peoria	6	
7	Bloomington Rehab & Health Care Center	Bloomington	Palm Terrace of Mattoon	Mattoon	Petersen Hospitality L	Peoria	7	
8	Casey Health Care Center	Casey	Piper city Rehab & Living Center	Piper City	Petersen Health Care	Peoria	8	
9	Charleston Rehab & Health Care Center	Charleston	Pleasant View Rehab & Health Care Center	Morrison	Petersen Management	Peoria	9	
10	Cisne Rehab & Health Care Center	Cisne	Polo Rehabilitation & Health Care Center	Polo	Petersen Health Busin	Peoria	10	
11	Countryview Care Center of Macomb	Macomb	Prairie City Rehab & Health Care Center	Prairie City	Petersen Health Care	Sulliva	11	
12	Counterview Terrace	Louisville	Robings Manor Nursing Home	Brighton	Midwest Health Oper	Peoria	12	
13	Cumberland Rehab & Health Care Center	Greenup	Rochelle Gardens	Rochelle	Petersen Health Prop	Peoria	13	
14	Decatur Rehab & Health Care Center	Decatur	Rochelle Rehab & Health Care Center	Rochelle	Petersen Roseville LL	Roseville	14	
15	Eastside Health & Rehabilitation Center'	Pittsfield	Rock Falls Rehab & Health Care Center	Rock Falls	Petersen Health Quali	Peoria	15	
16	Eastview Terrace	Sullivan	Arrow Wood Independent Living	Rock Falls	Petersen Health and	Peoria	16	
17	El Paso Health Care Center	El Paso	Roseville Rehab & Health Care Center	Roseville	Petersen 24, LLC	Peoria	17	
18	Enfield Rehab & Health Care Center	Enfield	Rosiclare Rehab & Health Care Center	Rosiclare			18	
19	Farmer City Rehab & Health Care Center	Farmer City	Royal Oaks Care Center	Kewanee			19	
20	Flanagan Rehab & Health Care Center	Flanagan	Sandwich Rehab & Health Care Center	Sandwich			20	
21	Flora Gardens Care Center	Flora	Iron Wood Independent Living	Sandwich			21	
22	Flora Health Care Center	Flora	Shawnee Rose Care Center	Harrisburg			22	
23	Fondulac Rehab & Health Care Center	East Peoria	Shelbyville Rehab & Health Care Center	Shelbyville			23	
24	Havana Health Care Center	Havana	South Elgin Rehab & Health Care Center	South Elgin			24	
25	Illini Heritage Rehab & Health Care	Champaign	Sullivan Health Care Center	Sullivan			25	
26	Jonesboro Rehab & Health Care Center	Jonesboro	Sunset Manor Nursing Home	Canton			26	
27	Kewanee Care Home	Kewanee	Swansea Rehab & Health Care	Swansea			27	
28	Lebanon Care Center	Lebanon	Timbercreek Rehab & Health Center	Pekin			28	
29	Marigold Rehab & Health Care Center	Galesburg	Toulon Health Care Center	Toulon			29	
30			Tuscola Health Care Center	Tuscola			30	

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

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Reference	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being Allocated Among	Cost Being Allocated	Cost Contained in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

* 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 2024 report.		\$	47,679	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.)		\$	50,599	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,920	3	
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,129	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.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	50,049	7	
Assessed Value from Real Estate Tax Bill:	2024	45,878	8		
Real Estate Tax Bill for Calendar Year:	2020	48,714	9		
	2021	48,310	10		
	2022	50,049	11		
	2023	47,679	12		
	2024	50,599	13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION\$ 17

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

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Eastside Health Rehab Center	COUNTY	Pike
---------------	------------------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0047456

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(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	\$ 50,598.94	\$ 50,598.94
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 50,598.94	\$ 50,598.94

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?

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

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:ExteriorBrickFrameSteel

Number of Stories1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

If YES, please indicate name of the facility.

IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long-Term Care	242,194	2005	\$	1
2					2
3	TOTALS	242,194		\$	3

	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

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

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	\$6,165	\$1,072	\$1,072	\$		\$1,490	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$6,165	\$1,072	\$1,072	\$		\$1,490	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)		\$	6,165
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$	1,072
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$	1,072
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$	1,490

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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?
16. Rental Amount for movable equipment: \$23,353Description: Copier, Medical Equipment
- ☐ YES☒ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent
12. /2026\$
13. /2027\$
14. /2028\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits
- (c) For in-house training programs only. Do not include fringe benefits
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	V39-03	hrs	\$	1,421	\$ 65,725	\$	1,421	\$ 65,725	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		132	6,605		132	6,605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		19,003	153,583		19,003	153,583	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescripts				163,255		163,255	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RT				12	2,839		12	2,839	12
13	Other (specify): See WTB	V39-02,03				11,980	13,913		25,893	13
14	TOTAL			\$	20,568	\$ 240,732	\$ 177,168	20,568	\$ 417,900	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.

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	\$ 1,065	\$	1
2	Cash-Patient Deposits	26,095		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	806,839		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,083		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,934,229		8
9	Other(specify):	6,727		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,840,038	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,165		16
17	Accumulated Depreciation (book methods)	(1,490)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): WIP	6,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,342	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,851,380	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,700,056	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,595		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,660		30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Related Party	2,180,202		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,930,513	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	(9,601)		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (9,601)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,920,912	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (69,532)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,851,380	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$124,606	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$124,606	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(194,138)	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)	\$(194,138)	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)	\$(69,532)	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,395,170	1
2	Discounts and Allowances for all Levels	(117,792)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,277,378	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	313,175	6
7	Oxygen	7,317	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 320,492	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	404	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,826	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,193	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 69,423	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	377	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 377	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	45,458	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,458	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,713,128	30

2		
II. Expenses		Amount
A. Operating Expenses		
31	General Services	802,075
32	Health Care	1,972,721
33	General Administration	2,297,484
B. Capital Expense		
34	Ownership	74,474
C. Ancillary Expense		
35	Special Cost Centers	443,002
36	Provider Participation Fee	317,510
D. Other Expenses (specify):		
37		
38		
39		
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,907,266
41	Income before Income Taxes (line 30 minus line 40)**	(194,138)
42	Income Taxes	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (194,138)

III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,443,388.00
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,658,577.00
46	MMAI-Medicaid is the Primary Payer	439,086.00
47	MMAI-Medicare is the Primary Payer	
48	Private Pay	585,372.00
49	Medicare Part A	921,433.00
50	Other-(specify) Managed Care	229,522.00
51	Other-(specify)	
52	Other-(specify)	
53	Other-(specify)	
54	Other-(specify)	
55	Other-(specify)	
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,277,378

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,408	1,512	\$ 61,084	\$ 40.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,713	3,939	331,592	84.18	3
4	Licensed Practical Nurses	9,719	10,345	354,656	34.28	4
5	CNAs & Orderlies	29,842	31,467	1,047,225	33.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	668	726	13,177	18.15	9
10	Activity Assistants	1,920	2,046	49,247	24.07	10
11	Social Service Workers	1,412	1,551	47,480	30.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,268	8,651	186,850	21.60	15
16	Dishwashers					16
17	Maintenance Workers	1,449	1,555	57,430	36.93	17
18	Housekeepers	6,567	6,987	143,618	20.56	18
19	Laundry					19
20	Administrator	1,384	1,512	84,888	56.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,343	1,436	51,773	36.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	498	517	7,403	14.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,191	72,244	\$ 2,436,423 *	\$ 33.72	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	32	\$ 2,804	V01-3	35
36	Medical Director	Monthly	15,600	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	32	\$ 18,404		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
Leigh A Crane	Administrator	0	\$ 84,888	Workers' Compensation Insurance	\$	9,853	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	3,436
				FICA Taxes		208,587	Health Care Worker Background Check	680
				Employee Health Insurance		26,372	(Indicate # of checks performed 68)	
				Employee Meals			Patient Background Checks	117
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	
				Other Benefits		2,025	Other Dues	2,904
TOTAL (agree to Schedule V, line 17, col. 1)							Other Licenses	3,679
(List each licensed administrator separately.)								
\$ 84,888								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Tutera Health Care Services - Management Fee			\$ 282,979	N/A			Out-of-State Travel	\$
							In-State Travel	6,683
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
\$ 282,979								
C. Professional Services				TOTAL			(agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount					
Gutnicki LLP	Legal Fees		\$ 2,248				TOTAL	\$ 6,683
Husch Blackwell	Legal Fees		337					
Livingston, Barger, Brandt	Legal Fees		462					
Meyer Magence	Legal Fees		88					
Reifers Holmes	Legal Fees		10					
Scott & Kraus	Legal Fees		23,063					
Daniel Maher Law Firm	Legal Fees		828					
Approved Admissions	Data Processing		300					
Compliance Consulting	Data Processing		4,400					
Creative Technology Solutions	Data Processing		3,315					
Various	Data Processing/Software		67,122					
Payroll	Payroll Processing		33,759					
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)								
\$ 135,932								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number		Eastside Health Rehab Center		STATE OF ILLINOIS		# 0047456		Report Period Beginning: 01/01/2025		Ending: 12/31/2025		Page 22	
XX. GENERAL INFORMATION:													
(1)		Are nursing employees (RN,LPN,NA) represented by a union'				<u>No</u>							
(2)		Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below Use the drop down list to identify the association.											
		<u>Association Name</u>				<u>Amount</u>							
		<u></u>				<u></u>							
		<u></u>				<u></u>							
		<u></u>				<u></u>				Total			
(3)		List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1											
		<u></u>				<u></u>							
		<u></u>				<u></u>							
		<u></u>				<u></u>				Total			
(4)		EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)											
		<u></u>				<u></u>							
		<u></u>				<u></u>							
		<u></u>				<u></u>				Total			
(5)		Indicate the total amount of both disposable and non-disposable incontinent expens and the location of this expense on Sch. V.				\$				Line <u>10</u>			
(6)		Have all costs reported on this form been determined using accounting procedures consistent with prior reports?				<u>Yes</u> If NO, attach a complete explanation.							
(7)		Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.				\$				<u>317,510</u>			
		This amount is to be recorded on line 42 of Schedule V.											
(8)		Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee'				<u>No</u> If YES, attach an explanation of the allocation.							
(9)		Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V'				<u>Yes</u>							
(10)		Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?				<u>No</u>				For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			
(11)		Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.				\$				<u>N/A</u>			
		Has any meal income been offset against related costs?				<u>No</u>				Indicate the amount. \$ <u>N/A</u>			
(12)		Travel and Transportation											
		a. Are there costs included for out-of-state travel?				<u>No</u>							
		If YES, attach a complete explanation.											
		b. Do you have a separate contract with the Department to provide medical transportation for residents?				<u>No</u>				If YES, please indicate the amount of income earned from such program during this reporting period. \$ <u>N/A</u>			
		c. What percent of all travel expense relates to transportation of nurses and patients?				<u>100%</u>							
		d. Have vehicle usage logs been maintained?				<u>Yes</u>							
		e. Are all vehicles stored at the nursing home during the night and all other times when not in use?				<u>Yes</u>							
		f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?											
		g. Does the facility transport residents to and from day training?				<u>No</u>							
		Indicate the amount of income earned from providing such transportation during this reporting period.				\$ <u>N/A</u>							
(13)		Has an audit been performed by an independent certified public accounting firm				<u>No</u>							
		Firm Name:				<u>N/A</u>							
(14)		Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?				<u>Yes</u>							
(15)		Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.				<u>Yes</u>							
		Attach invoices and a summary of services for all architect and appraisal fees:											