



Facility Name & ID Number Eastview Terrace

# 0046060 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</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>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,828</u>	<u>3,125</u>	<u>811</u>	<u>14,764</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>10,828</u>	<u>3,125</u>	<u>811</u>	<u>14,764</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.21%

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)

Meals for Inmates

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 2/1/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/1/2000 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 9 and days of care provided 811

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

\* 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	127,400	16,241		143,641		143,641	2,909	146,550		
2	Food Purchase		141,263		141,263		141,263	(95,706)	45,557		
3	Housekeeping	77,033	18,530		95,563		95,563	29	95,592		
4	Laundry		2,344		2,344		2,344		2,344		
5	Heat and Other Utilities			50,693	50,693		50,693	221	50,914		
6	Maintenance	26,199	11,066	18,783	56,048		56,048	1,425	57,473		
7	Other (specify):* Home Off. Ben. All.							165	165		
8	<b>TOTAL General Services</b>	230,632	189,444	69,476	489,552		489,552	(90,957)	398,595		
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		
10	Nursing and Medical Records	685,793	41,159	12,055	739,007		739,007	10	739,017		
10a	Therapy		116	54,138	54,254		54,254		54,254		
11	Activities	19,488	16	34,223	53,727		53,727	(860)	52,867		
12	Social Services	24,625			24,625		24,625		24,625		
13	CNA Training										
14	Program Transportation										
15	Other (specify):* Home Off. Ben. All.										
16	<b>TOTAL Health Care and Programs</b>	729,906	41,291	111,416	882,613		882,613	(850)	881,763		
	<b>C. General Administration</b>										
17	Administrative			67,200	67,200		67,200	(11,100)	56,100		
18	Directors Fees										
19	Professional Services			6,355	6,355		6,355	6,134	12,489		
20	Dues, Fees, Subscriptions & Promotions			3,573	3,573		3,573	(580)	2,993		
21	Clerical & General Office Expenses	27,298	2,782	134,531	164,611		164,611	35,993	200,604		
22	Employee Benefits & Payroll Taxes			183,751	183,751		183,751		183,751		
23	Inservice Training & Education							58	58		
24	Travel and Seminar							3	3		
25	Other Admin. Staff Transportation			4,337	4,337		4,337	2,693	7,030		
26	Insurance-Prop.Liab.Malpractice			34,255	34,255		34,255	520	34,775		
27	Other (specify):* Home Off. Ben. All.							3,337	3,337		
28	<b>TOTAL General Administration</b>	27,298	2,782	434,002	464,082		464,082	37,058	501,140		
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	987,836	233,517	614,894	1,836,247		1,836,247	(54,749)	1,781,498		

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

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

Facility Name &amp; ID Number

Eastview Terrace

#0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			39,890	39,890	39,890	3,143	43,033				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,634	84,634	84,634	(8,119)	76,515				32
33	Real Estate Taxes			22,413	22,413	22,413	234	22,647				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,268	5,268	5,268	431	5,699				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			152,205	152,205	152,205	(4,311)	147,894				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,526		40,526	40,526		40,526				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,603	117,603	117,603		117,603				42
43	Other (specify):* Non-allowable Costs		248	86,788	87,036	87,036	(87,036)					43
44	<b>TOTAL Special Cost Centers</b>		40,774	204,391	245,165	245,165	(87,036)	158,129				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	987,836	274,291	971,490	2,233,617	2,233,617	(146,096)	2,087,521				45

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

Facility Name & ID Number Eastview Terrace

# 0046060

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,018)	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	753	30		9
10	Interest and Other Investment Income	(12,095)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	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	(29,220)	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	(49,538)	43		24
25	Fund Raising, Advertising and Promotional	(2,773)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(99,999)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (196,038)		\$	30

<b>BHF USE ONLY</b>						
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	
		<b>Amount</b>	<b>Reference</b>	
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)	49,942	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 49,942		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (146,096)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Eastview Terrace

ID# 0046060

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,810)	43	1
2	X-Rays-Part A	(2,095)	43	2
3	Resident Flowers	(243)	43	3
4	Offset of Office Supplies Income	(62)	21	4
5	Offset of Jail Meals Income	(92,750)	2	5
6	Offset of Chamber of Commerce Dues	(970)	20	6
7	Disallowed Special Events	(209)	43	7
8	Offset of Transportation Income	(860)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(99,999)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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	2,909	0	0	0	0	0	0	0	0	0	2,909	1
2	Food Purchase	(95,768)	62	0	0	0	0	0	0	0	0	0	(95,706)	2
3	Housekeeping	0	29	0	0	0	0	0	0	0	0	0	29	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	221	0	0	0	0	0	0	0	0	0	221	5
6	Maintenance	0	1,425	0	0	0	0	0	0	0	0	0	1,425	6
7	Other (specify):*	0	165	0	0	0	0	0	0	0	0	0	165	7
8	<b>TOTAL General Services</b>	<b>(95,768)</b>	<b>4,811</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(90,957)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10	0	0	0	0	0	0	0	0	0	10	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(860)	0	0	0	0	0	0	0	0	0	0	(860)	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	<b>TOTAL Health Care and Programs</b>	<b>(860)</b>	<b>10</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(850)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(11,100)	0	0	0	0	0	0	0	0	0	(11,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,134	0	0	0	0	0	0	0	0	0	6,134	19
20	Fees, Subscriptions & Promotions	(970)	0	390	0	0	0	0	0	0	0	0	(580)	20
21	Clerical & General Office Expenses	(62)	0	36,055	0	0	0	0	0	0	0	0	35,993	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	58	0	0	0	0	0	0	0	0	58	23
24	Travel and Seminar	0	0	3	0	0	0	0	0	0	0	0	3	24
25	Other Admin. Staff Transportation	0	0	2,693	0	0	0	0	0	0	0	0	2,693	25
26	Insurance-Prop.Liab.Malpractice	0	0	520	0	0	0	0	0	0	0	0	520	26
27	Other (specify):*	0	0	3,337	0	0	0	0	0	0	0	0	3,337	27
28	<b>TOTAL General Administration</b>	<b>(1,032)</b>	<b>(4,966)</b>	<b>43,056</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37,058</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(97,660)</b>	<b>(145)</b>	<b>43,056</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(54,749)</b>	<b>29</b>



## STATE OF ILLINOIS

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	753	0	2,390	0	0	0	0	0	0	0	0	3,143	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,095)	0	3,976	0	0	0	0	0	0	0	0	(8,119)	32
33	Real Estate Taxes	0	0	234	0	0	0	0	0	0	0	0	234	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	431	0	0	0	0	0	0	0	0	431	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(11,342)</b>	<b>0</b>	<b>7,031</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,311)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(87,036)	0	0	0	0	0	0	0	0	0	0	(87,036)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(87,036)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(87,036)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(196,038)	(145)	50,087	0	0	0	0	0	0	0	0	(146,096)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,909	\$ 2,909	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	62	62	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	221	221	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,425	1,425	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	165	165	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10	10	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	67,200	Petersen Health Care, Inc.	100.00%	56,100	(11,100)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,134	6,134	12
13	V							13
14	Total		\$ 67,200			\$ 67,055	\$ * (145)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 390	\$	390	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,055		36,055	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	58		58	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	3		3	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,693		2,693	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	520		520	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,337		3,337	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,390		2,390	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,976		3,976	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	234		234	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%	431		431	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		\$			\$ 50,087	\$ *	50,087	39

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

Facility Name &amp; ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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 J	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	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	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	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 &amp; ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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 &amp; ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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

Facility Name & ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Cornerstone Health and Rehabilitation	Peoria				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 &amp; ID Number

Eastview Terrace

#

0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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



Facility Name & ID Number Eastview Terrace

# 0046060 Report Period Beginning: 1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,560,986	75	\$ 307,592	\$ 295,212	14,764	\$ 2,909	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	14,764	62	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	14,764	29	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	14,764	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	14,764	221	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	14,764	1,425	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	14,764	165	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	14,764	10	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	14,764	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	14,764	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	14,764	56,100	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	14,764	6,134	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	14,764	390	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	14,764	36,055	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	14,764	58	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	14,764	3	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	14,764	2,693	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	14,764	520	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	14,764	3,337	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	14,764	2,390	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	14,764	3,976	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	14,764	234	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	14,764	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	14,764	431	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 117,142	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 2,532,001	12/31/2013	Varies	\$ 84,634	1				
2												2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 3,075,000	\$ 2,532,001			\$ 84,634	9				
<b>B. Non-Facility Related*</b>																
10												10				
11											(12,095)	11				
12											3,976	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (8,119)	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 3,075,000	\$ 2,532,001			\$ 76,515	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.			\$	<u>22,068</u>	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.)	2012		\$	<u>21,909</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(159)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>22,572</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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.				234	
<b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>22,647</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>12,163</u>			8
	2009	<u>12,343</u>			9
	2010	<u>12,459</u>			10
	2011	<u>21,426</u>			11
	2012	<u>21,909</u>			12
<u>Accrual based on prior year tax bill.</u>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		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.**



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                 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Eastview Terrace

# 0046060 Report Period Beginning:

1/1/2013 Ending:

12/31/2013

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,082 B. General Construction Type: Exterior Block Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>217,546</u>	<u>2000</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>217,546</b>		<b>\$ 100,000</b>	<b>3</b>

Facility Name &amp; ID Number Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	2000	1976	\$ 982,565	\$	39	\$ 25,194	\$ 25,194	\$ 351,666	4
5	6	2000	1985							5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Water Heater	2000		4,800		7			4,800	9
10	Concrete Pad	2000		500		20	25	25	273	10
11	Painting Exterior Building	2000		2,480		5			2,480	11
12	Fence	2000		3,953		15	264	264	3,479	12
13	Asphalt Parking Lot	2000		2,370		15	158	158	1,896	13
14	Carpet	2000		503		7			503	14
15	Flooring	2001		72,265		39	1,853	1,853	25,462	15
16	Remodeling	2001		6,245		39	160	160	2,217	16
17	Roofing	2001		2,159		39	55	55	752	17
18	Roofing	2001		12,000		39	308	308	4,064	18
19	Replacement - Glass	2001		1,179		7			1,179	19
20	Medicare wing upgrade	2002		89,018		39	2,283	2,283	28,904	20
21	Roofing	2002		14,200		39	364	364	4,569	21
22	Flooring	2002		4,263		39	109	109	1,358	22
23	Architects Fee	2002		1,916		39	49	49	589	23
24	Wall hangings	2002		3,220		7			3,220	24
25	Paving of Parking Lot	2004		4,200		15	280	280	2,683	25
26	Window Balance	2004		1,714		7			1,714	26
27	Driveway renovation	2005		1,100		20	55	55	489	27
28	Grease interceptor	2005		15,589		20	779	779	6,399	28
29	Sidewalks	2005		4,919		20	246	246	1,995	29
30	Sealcoating	2006		5,650		8	706	706	5,295	30
31	Pipe Work	2006		3,700		25	148	148	1,110	31
32	Sidewalks	2007		4,420		15	295	295	1,917	32
33	Replace Exterior Storage Shed (Including Demolition of Old)	2008		5,000		20	250	250	1,375	33
34	Wall Flashing-Dining Room	2011		4,700		15	314	314	785	34
35	Sprinkler System Replacement	2011		45,990		15	3,066	3,066	7,665	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

Facility Name & ID Number Eastview Terrace

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Parking Lot Grading	2013	\$ 3,250	\$	7	\$ 232	\$ 232	\$ 232	37
38	Vinyl Flooring-Hallways, Common Area, and Offices	2013	29,569		25	591	591	591	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	Land Improvements Booked			951			(951)		63
64	Building Booked			25,194			(25,194)		64
65	Building Improvement Booked			10,733			(10,733)		65
66									66
67	2013-Home Office Allocation-Building Improvements		6,942			166	166		67
68	2013-Home Office Allocation-Land Improvements		648			41	41		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,341,027	\$ 36,878		\$ 37,991	\$ 1,113	\$ 469,661	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	\$ 307,682	\$ 2,661	\$ 2,369	\$ (292)	5-10 yrs.	\$ 296,938	71
72	Current Year Purchases	9,805	350	490	140	10 yrs.	490	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,183	2,183			74
75	TOTALS	\$ 317,487	\$ 3,011	\$ 5,042	\$ 2,031		\$ 297,428	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	Resident Care	Ford Econoline Van 2007	2007	28,328	\$	\$	\$		\$ 28,328	76
77										77
78										78
79										79
80	TOTALS			\$ 28,328	\$	\$	\$		\$ 28,328	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,786,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,889	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,033	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,144	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 795,417	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending: 12/31/2013

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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: \$ 5,699

Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**Eastview Terrace**  
**0046060**  
**Period Beginning** 1/1/2013  
**Period End** 12/31/2013

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 1,727
Dishwasher	-
Laundry Equipment	-
Copier	3,541
Home Office Allocation	431
	<u>5,699</u>

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 1/1/2013 Ending: 12/31/2013  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	499	\$ 7,486	\$	499	\$ 7,486	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		587	8,809		587	8,809	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,513	37,693	116	2,513	37,809	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				40,526		40,526	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			10	150		10	150	13	
14	<b>TOTAL</b>			\$	3,609	\$ 54,138	\$ 40,642	3,609	\$ 94,780	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eastview Terrace# 0046060Report Period Beginning: 1/1/2013

Ending:

12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,822,339	\$ 3,822,339	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>147,730</u> )	355,229	355,229	3
4	Supply Inventory (priced at )	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,056	24,056	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	345,608	345,608	8
9	Other(specify): <u>A/R Prior Owner</u>	253	253	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,559,778	\$ 4,559,778	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114,270	100,000	13
14	Buildings, at Historical Cost	982,565	989,507	14
15	Leasehold Improvements, at Historical Cost	330,087	351,520	15
16	Equipment, at Historical Cost	352,329	345,815	16
17	Accumulated Depreciation (book methods)	(790,938)	(795,417)	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 (spec <u>Goodwill</u> )	320,669	320,669	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,308,982	\$ 1,312,094	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,868,760	\$ 5,871,872	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 384,244	\$ 384,244	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,658	72,658	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,418	4,418	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,572	22,572	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	51,458	51,458	36
37	<u>Accrued Management Fees</u>	37,683	37,683	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 573,033	\$ 573,033	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,532,001	2,532,001	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P-Other</u>	5,458	5,458	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,537,459	\$ 2,537,459	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,110,492	\$ 3,110,492	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,758,268	\$ 2,761,380	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,868,760	\$ 5,871,872	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 2,885,656	1
2	Restatements (describe):		2
3	<b>Rounding</b>	(2)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 2,885,654	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(127,386)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (127,386)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,758,268	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Eastview Terrace# 0046060Report Period Beginning: 1/1/2013Ending: 12/31/2013

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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$	1,914,745	1
2	Discounts and Allowances for all Levels		(110,929)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$	1,803,816	3
<b>B. Ancillary Revenue</b>				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		114,067	6
7	Oxygen		1,036	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	115,103	8
<b>C. Other Operating Revenue</b>				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals		3,018	14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs		71,802	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray		5,665	20
21	Other Medical Services		1,060	21
22	Laundry			22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	81,545	23
<b>D. Non-Operating Revenue</b>				
24	Contributions			24
25	Interest and Other Investment Income***		12,095	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	12,095	26
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>			27
28	Miscellaneous & Jail Revenue		92,812	28
28a	Transportation Revenue		860	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	93,672	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$	2,106,231	30

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services		489,552	31
32	Health Care		882,613	32
33	General Administration		464,082	33
<b>B. Capital Expense</b>				
34	Ownership		152,205	34
<b>C. Ancillary Expense</b>				
35	Special Cost Centers		127,562	35
36	Provider Participation Fee		117,603	36
<b>D. Other Expenses (specify):</b>				
37				37
38				38
39				39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$	2,233,617	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>		(127,386)	41
42	<b>Income Taxes</b>			42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$	(127,386)	43

III. Net Inpatient Revenue detailed by Payer Source				
44	Medicaid - Net Inpatient Revenue	\$	1,282,305	44
45	Private Pay - Net Inpatient Revenue		386,440	45
46	Medicare - Net Inpatient Revenue		145,245	46
47	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>		(10,174)	47
48	Other-(specify)			48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	1,803,816	49

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

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

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

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



Facility Name & ID Number Eastview Terrace

# 0046060

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

**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	1,797	1,797	\$ 51,846	\$ 28.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	164	165	3,736	22.64	3
4	Licensed Practical Nurses	12,905	13,395	254,981	19.04	4
5	CNAs & Orderlies	31,462	32,321	335,150	10.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,604	1,650	18,223	11.04	9
10	Activity Assistants	141	141	1,265	8.97	10
11	Social Service Workers	1,775	2,043	24,625	12.05	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,260	15.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,233	10,500	96,140	9.16	15
16	Dishwashers					16
17	Maintenance Workers	1,709	1,908	26,199	13.73	17
18	Housekeepers	7,807	8,015	77,033	9.61	18
19	Laundry					19
20	Administrator	2,080	2,080	56,100	26.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,790	1,848	27,298	14.77	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CPC</u>	1,855	1,984	40,080	20.20	33
34	TOTAL (lines 1 - 33)	77,402	79,927	\$ 1,043,936 *	\$ 13.06	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	11,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,001	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)		\$ 14,001		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	28	\$ 953	L10, C3	50
51	Licensed Practical Nurses	334	7,735	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	362	\$ 8,688		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	
Adam Pullen	Administrator	0	\$ 56,100	Workers' Compensation Insurance	\$ 38,746	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	24,792	Advertising: Employee Recruitment		
				FICA Taxes	78,229	Health Care Worker Background Check		
				Employee Health Insurance	39,188	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	33 338	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	275	
				Employee Relations	2,086	Miscellaneous Dues & Subscriptions	970	
				Employee Retirement	710	Home Office Allocation	390	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 56,100			Less: Public Relations Expense	(970)	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 67,200					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 67,200					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Honkamp Krueger & Co.	Accounting Fees		\$ 467				Out-of-State Travel	\$
Mediacom	Computer Services		1,395					
E-Health Data Solutions	Computer Services		740					
Allscripts	Computer Services		1,673	N/A			In-State Travel	
Heart Technologies	Computer Services		1,900					
Coles County Sheriff	Filing Fees		30				Seminar Expense	
Moultrie County Circuit Clerk	Filing Fees		150				Home Office Allocation	3
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 6,355	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3

\* Attach copy of IMRF notifications

\*\*See instructions.

Eastview Terrace  
0046060  
Period Beginning  
Period End

1/1/2013  
12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,355
<b>Home Office Allocation</b>		
SmithAmundsen	Legal	365
Cole, Schotz, Meisel	Legal	201
Black, Hedin, Ballard	Legal	18
Ginoli & Company	Accountants	664
Miscellaneous	Computer Services	55
Odessian LLC	Computer Services	29
CCH	Computer Services	8
Lexis-Nexis	Computer Services	3
Ipanema Solutions	Computer Services	8
Macquarie Technology Services	Computer Services	52
Advanced Answers on Demand	Computer Services	2700
TeamViewer	Computer Services	9
Stratus Networks	Computer Services	218
Kemper Technology	Computer Services	168
AT&T	Computer Services	3
Medifax	Computer Services	24
Vision Share/Ability Network	Computer Services	370
Barracuda	Computer Services	67
CIAN	Computer Services	89
Comcast	Computer Services	20
Emdeon	Computer Services	30
Marotta Gund Budd & Dzera	Other Prof Fees	826
David Budde	Other Prof Fees	17
Pharmacy Price Mangement	Other Prof Fees	68
All Scripts	Other Prof Fees	122

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

12,489

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Eastview Terrace

# 0046060

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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. \$ 14,803 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. \$ 117,603  
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. \$ 3,018
- (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. \$ 860
- 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? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (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.