FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0053009

Facility Name: Eastview Terrace

Address: 100 Eastview Place (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-7367 **Fax #** (217) 728-8405

HFS ID Number:

Date of Initial License for Current Owners: 02/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/14 to 12/31/14 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.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	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	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,683	3,735	1,378	18,796	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,683	3,735	1,378	18,796	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.74%

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 [X] NO [ ]

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 2/1/2000

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1,012

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Eastview Terrace # 0053009 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,165	16,826		150,991		150,991	6,373	157,364			1
2	Food Purchase		164,511		164,511		164,511	(79,367)	85,144			2
3	Housekeeping	90,975	18,182		109,157		109,157	39	109,196			3
4	Laundry	1,362	12,194		13,556		13,556		13,556			4
5	Heat and Other Utilities			71,956	71,956		71,956	239	72,195			5
6	Maintenance	29,541	13,359	19,449	62,349		62,349	2,396	64,745			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	256,043	225,072	91,405	572,520		572,520	(70,320)	502,200			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	23	12,023			9
10	Nursing and Medical Records	805,329	59,118	42,157	906,604		906,604	(2,206)	904,398			10
10a	Therapy		37	115,272	115,309		115,309		115,309			10a
11	Activities	21,544	49	22,858	44,451		44,451	(94)	44,357			11
12	Social Services	24,942	10		24,952		24,952		24,952			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	851,815	59,214	192,287	1,103,316		1,103,316	(2,277)	1,101,039			16
	C. General Administration											
17	Administrative			85,000	85,000		85,000	(31,579)	53,421			17
18	Directors Fees											18
19	Professional Services			8,653	8,653		8,653	7,802	16,455			19
20	Dues, Fees, Subscriptions & Promotions			7,569	7,569		7,569	43	7,612			20
21	Clerical & General Office Expenses	30,191	5,606	12,803	48,600		48,600	70,564	119,164			21
22	Employee Benefits & Payroll Taxes			181,338	181,338		181,338	15,041	196,379			22
23	Inservice Training & Education							29	29			23
24	Travel and Seminar							25	25			24
25	Other Admin. Staff Transportation			3,411	3,411		3,411	3,870	7,281			25
26	Insurance-Prop.Liab.Malpractice			30,680	30,680		30,680	558	31,238			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	30,191	5,606	329,454	365,251		365,251	66,353	431,604			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,138,049	289,892	613,146	2,041,087		2,041,087	(6,244)	2,034,843			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eastview Terrace #0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,731	45,731		45,731	2,430	48,161			30
31	Amortization of Pre-Op. & Org.							1,289	1,289			31
32	Interest			73,099	73,099		73,099	8,294	81,393			32
33	Real Estate Taxes			23,642	23,642		23,642	222	23,864			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,498	5,498		5,498	943	6,441			35
36	Other (specify):*											36
37	**TOTAL Ownership**			147,970	147,970		147,970	13,178	161,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,734		43,734		43,734		43,734			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,854	143,854		143,854		143,854			42
43	Other (specify):*		209	124,448	124,657		124,657	(124,657)				43
44	**TOTAL Special Cost Centers**		43,943	268,302	312,245		312,245	(124,657)	187,588			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,138,049	333,835	1,029,418	2,501,302		2,501,302	(117,723)	2,383,579			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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,713)	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	(295)	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(123)	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	(68,669)	43		18
19	Entertainment				19
20	Contributions	(9)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	43		24
25	Fund Raising, Advertising and Promotional	(3,157)	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	(85,045)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,013)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	89,290	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 89,290		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,723)		37

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

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

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

Eastview Terrace

ID# 0053009

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,464)	43	1
2	X-Rays-Part A	(1,698)	43	2
3	Resident Flowers	(86)	43	3
4	Offset of Office Supplies Income	(167)	21	4
5	Offset of Jail Meals Income	(77,728)	2	5
6	Offset of Chamber of Commerce Dues	(133)	20	6
7	Disallowed Special Events	(430)	43	7
8	Offset of Transportation Income	(94)	11	8
9	Offset of Nursing Supplies Income	(2,224)	10	9
10	Disallowed Pet Expense	(21)	43	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
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26				26
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(85,045)		49

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 2,776	$ 2,776	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	66	66	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	14	14	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	187	187	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,053	1,053	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	23	23	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	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		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	2,394	2,394	12
13	V								13
14	Total			$			$ 6,514	$ * 6,514	14

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 133	$ 133	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,250	31,250	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,421	1,421	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	16	16	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	10	10	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,527	2,527	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	445	445	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,552	2,552	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,623	1,623	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	125	125	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	642	642	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			$			$ 40,744	$ * 40,744	39

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Quality, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Quality, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Quality, LLC	100.00%	0		17
18	V	5	Utilities		Petersen Health Quality, LLC	100.00%	0		18
19	V	6	Maintenance		Petersen Health Quality, LLC	100.00%	0		19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		20
21	V	9	Medical Director		Petersen Health Quality, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Quality, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health Quality, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health Quality, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health Quality, LLC	100.00%	0		26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	0		27
28	V	21	Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Quality, LLC	100.00%	0		29
30	V	23	Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		30
31	V	24	Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		31
32	V	25	Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		34
35	V	30	Depreciation		Petersen Health Quality, LLC	100.00%	0		35
36	V	31	Amortization of Pre-Op. & Org.		Petersen Health Quality, LLC	100.00%	1,289	1,289	36
37	V	32	Interest		Petersen Health Quality, LLC	100.00%	6,444	6,444	37
38	V	33	Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		38
39	Total			$			$ 7,733	$ * 7,733	39

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 3,597	$ 3,597	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	8	8	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	25	25	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	52	52	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,343	1,343	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	17	17	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	85,000	Petersen Health Care Management, Inc.	100.00%	53,421	(31,579)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	5,408	5,408	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	43	43	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,481	39,481	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,620	13,620	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	13	13	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,343	1,343	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	113	113	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	173	173	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	229	229	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	97	97	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	301	301	38
39	Total			$ 85,000			$ 119,299	$ * 34,299	39

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	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	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6	N/A										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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 231,473	$ 220,289	18,857	$ 2,776	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	18,857	66	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	18,857	14	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	18,857	187	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	18,857	1,053	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,857	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	18,857	23	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	18,857	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	18,857	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,857	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	18,857	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	18,857	2,394	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	18,857	133	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	18,857	31,250	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	18,857	1,421	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	18,857	16	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	18,857	10	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	18,857	2,527	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	18,857	445	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	18,857	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	18,857	2,552	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	18,857	1,623	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	18,857	125	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	18,857	642	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 47,258	25

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	28,734	6	$	$	18,857	$	1
2	2	Food	Resident Days	28,734	6			18,857		2
3	3	Housekeeping	Resident Days	28,734	6			18,857		3
4	5	Utilities	Resident Days	28,734	6			18,857		4
5	6	Maintenance	Resident Days	28,734	6			18,857		5
6	7	Mgmt. Allocation of Benefits	Resident Days	28,734	6			18,857		6
7	9	Medical Director	Resident Days	28,734	6			18,857		7
8	10	Nursing and Medical Records	Resident Days	28,734	6			18,857		8
9	10A	Therapy	Resident Days	28,734	6			18,857		9
10	15	Mgmt. Allocation of Benefits	Resident Days	28,734	6			18,857		10
11	17	Administrative	Resident Days	28,734	6			18,857		11
12	19	Professional Services	Resident Days	28,734	6			18,857		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	28,734	6			18,857		13
14	21	Clerical and General Office	Resident Days	28,734	6			18,857		14
15	22	Employee Benefits and Payroll Ta	Resident Days	28,734	6			18,857		15
16	23	Inservice Training & Education	Resident Days	28,734	6			18,857		16
17	24	Travel and Seminar	Resident Days	28,734	6			18,857		17
18	25	Other Admin. Staff Transport.	Resident Days	28,734	6			18,857		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	28,734	6			18,857		19
20	27	Mgmt. Allocation of Benefits	Resident Days	28,734	6			18,857		20
21	30	Depreciation	Resident Days	28,734	6			18,857		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	28,734	6	7,963		18,857	1,289	22
23	32	Interest	Resident Days	28,734	6	39,818		18,857	6,444	23
24	33	Real Estate Taxes	Resident Days	28,734	6			18,857		24
25	TOTALS					$ 47,781	$		$ 7,733	25

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 299,961	$ 294,997	18,857	$ 3,597	1
2	2	Food	Resident Days	1,572,338	77	675		18,857	8	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	18,857	25	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		18,857	52	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	18,857	1,343	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,857		6
7	9	Medical Director	Resident Days	1,572,338	77			18,857		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		18,857	17	8
9	10A	Therapy	Resident Days	1,572,338	77			18,857		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,857		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	18,857	53,421	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		18,857	5,408	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		18,857	43	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	18,857	39,481	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		18,857	13,620	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		18,857	13	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		18,857	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		18,857	1,343	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		18,857	113	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			18,857		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		18,857	173	21
22	32	Interest	Resident Days	1,572,338	77	19,133		18,857	229	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		18,857	97	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		18,857	301	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 119,299	25

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	$ 3,075,000	$ 1,564,450	12/31/2013	Varies	$ 73,099	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,075,000	$ 1,564,450			$ 73,099	9
	B. Non-Facility Related*											
10								Interest Income Offset			(2)	10
11								Home Office Allocation-PHC			1,623	11
12								Home Office Allocation-PHQ			6,444	12
13								Home Office Allocation-PHCM			229	13
14	TOTAL Non-Facility Related						$	$			$ 8,294	14
15	TOTALS (line 9+line14)						$ 3,075,000	$ 1,564,450			$ 81,393	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.)**

Facility Name & ID Number Eastview Terrace # 0053009 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 22,572	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.)	**2013**	$ 22,766	2
3. Under or (over) accrual (line 2 minus line 1).		$ 194	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,448	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. **Home Office Allocation**		222	
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.		$ 23,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	12,343	8
	2010	12,459	9
	2011	21,426	10
	2012	21,909	11
	2013	22,766	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0053009

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-01-202-037	Long-Term Care Facility	$ 22,765.68	$ 22,765.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,765.68	$ 22,765.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

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

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 1,289 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	Facility	217,546	2000	$ 100,000	1
2					2
3	TOTALS	217,546		$ 100,000	3

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		2000	1976	$ 982,565	$	39	$ 25,194	$ 25,194	$ 376,860	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater			2000	4,800		7			4,800	9
10	Concrete Pad			2000	500		20	25	25	298	10
11	Painting Exterior Building			2000	2,480		5			2,480	11
12	Fence			2000	3,953		15	264	264	3,743	12
13	Asphalt Parking Lot			2000	2,370		15	158	158	2,054	13
14	Carpet			2000	503		7			503	14
15	Flooring			2001	72,265		39	1,853	1,853	27,315	15
16	Remodeling			2001	6,245		39	160	160	2,377	16
17	Roofing			2001	2,159		39	55	55	807	17
18	Roofing			2001	12,000		39	308	308	4,372	18
19	Replacement - Glass			2001	1,179		7			1,179	19
20	Medicare wing upgrade			2002	89,018		39	2,283	2,283	31,187	20
21	Roofing			2002	14,200		39	364	364	4,933	21
22	Flooring			2002	4,263		39	109	109	1,467	22
23	Architects Fee			2002	1,916		39	49	49	638	23
24	Wall hangings			2002	3,220		7			3,220	24
25	Paving of Parking Lot			2004	4,200		15	280	280	2,963	25
26	Window Balance			2004	1,714		7			1,714	26
27	Driveway renovation			2005	1,100		20	55	55	544	27
28	Grease interceptor			2005	15,589		20	779	779	7,178	28
29	Sidewalks			2005	4,919		20	246	246	2,241	29
30	Sealcoating			2006	5,650		8	355	355	5,650	30
31	Pipe Work			2006	3,700		25	148	148	1,258	31
32	Sidewalks			2007	4,420		15	295	295	2,212	32
33	Replace Exterior Storage Shed (Including Demolition of Old)			2008	5,000		20	250	250	1,625	33
34	Wall Flashing-Dining Room			2011	4,700		15	314	314	1,099	34
35	Sprinkler System Replacement			2011	45,990		15	3,066	3,066	10,731	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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Parking Lot Grading	2013	$ 3,250	$	7	$ 464	$ 464	$ 696	37
38	Vinyl Flooring-Hallways, Common Area, and Offices	2013	29,569		25	1,182	1,182	1,773	38
39	Wandering Alert System	2014	4,295		7	256	256	256	39
40	Block Wall Repair	2014	3,800		7	226	226	226	40
41	Parking Lot Repaving	2014	44,457		15	988	988	988	41
42	Roof Replacement-North and West Section	2014	39,850		25	531	531	531	42
43	Windows for North Section	2014	5,500		15	122	122	122	43
44	Irrigation Installation	2014	4,790		15	80	80	80	44
45	Cabinet and Countertop Replacement	2014	2,865		15	32	32	32	45
46	Window Replacement-North and West Section	2014	18,199		15	202	202	202	46
47	Repairs and Downspout Replacement-South Section	2014	16,192		15	90	90	90	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			14,320			(14,320)		65
66									66
67	2014-Home Office Allocation-Building Improvements		8,803			211	211		67
68	2014-Home Office Allocation-Land Improvements		822			45	45		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,483,010	$ 40,465		$ 41,039	$ 574	$ 510,444	70

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 33,499	$ 3,963	$ 3,350	$ (613)	5-10 yrs.	$ 16,788	71
72	Current Year Purchases	39,430	1,303	1,303		10 yrs.	1,303	72
73	Fully Depreciated Assets	283,990					283,990	73
74	Home Office Allocation			2,469	2,469			74
75	TOTALS	$ 356,919	$ 5,266	$ 7,122	$ 1,856		$ 302,081	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)	$ 1,968,257	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 45,731	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,161	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,430	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 840,853	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 6,441 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					18
19					19
20					20
21	TOTAL		$	$	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
0053009
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	3,740
Dishwasher		-
Laundry Equipment		-
Copier		1,758
Home Office Allocation		943
		6,441

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	1,887	$ 28,300	$	1,887	$ 28,300	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,630	24,454		1,630	24,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,168	62,518	37	4,168	62,555	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				43,734		43,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,685	$ 115,272	$ 43,771	7,685	$ 159,043	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 # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 85,780	$ 85,780	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 170,669)	433,230	433,230	3
4	Supply Inventory (priced at Cost)	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,140	27,140	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	600,222	600,222	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,158,665	$ 1,158,665	10
	B. Long-Term Assets			
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	991,368	14
15	Leasehold Improvements, at Historical Cost	470,035	491,642	15
16	Equipment, at Historical Cost	388,392	385,247	16
17	Accumulated Depreciation (book methods)	(836,667)	(840,853)	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 (spe Goodwill	320,669	320,669	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,439,264	$ 1,448,073	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,597,929	$ 2,606,738	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 724,916	$ 724,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,209	74,209	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,152	34,152	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,448	23,448	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	52,317	52,317	36
37	Accrued Management Fees	108,447	108,447	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,017,489	$ 1,017,489	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,564,450	1,564,450	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	653	653	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,565,103	$ 1,565,103	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,582,592	$ 2,582,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,337	$ 24,146	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,597,929	$ 2,606,738	48

***(See instructions.)**

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,758,268	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,758,270	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	274,462	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)**	$ 274,462	17
	B. Transfers (Itemize):		
18	**Transfer of Net Assets due to Corporate Restructuring**	(3,017,395)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,017,395)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 15,337	24 *

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,585,095	1
2	Discounts and Allowances for all Levels	(211,278)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,373,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	230,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 230,800	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	1,713	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	80,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,230	20
21	Other Medical Services	2,579	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 90,932	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Jail Revenue	80,119	28
28a	Transportation Revenue	94	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 80,213	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,775,764	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	572,520	31
32	Health Care	1,103,316	32
33	General Administration	365,251	33
	B. Capital Expense		
34	Ownership	147,970	34
	C. Ancillary Expense		
35	Special Cost Centers	168,391	35
36	Provider Participation Fee	143,854	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,501,302	40
41	**Income before Income Taxes (line 30 minus line 40)****	274,462	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 274,462	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,580,679	44
45	Private Pay - Net Inpatient Revenue	529,416	45
46	Medicare - Net Inpatient Revenue	118,179	46
47	Other-(specify) Insurance Net Revenue	152,481	47
48	Other-(specify) Charity Therapy Allowance	(6,938)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,373,817	49

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

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

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

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 60,375	$ 29.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,647	2,679	67,303	25.12	3
4	Licensed Practical Nurses	12,052	12,653	252,332	19.94	4
5	CNAs & Orderlies	33,559	34,239	376,700	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,847	1,918	21,544	11.23	9
10	Activity Assistants					10
11	Social Service Workers	1,880	1,964	24,942	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,013	30,633	15.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,109	11,368	103,532	9.11	15
16	Dishwashers					16
17	Maintenance Workers	2,099	2,187	29,541	13.51	17
18	Housekeepers	9,240	9,517	90,975	9.56	18
19	Laundry	162	162	1,362	8.41	19
20	Administrator	2,080	2,183	53,421	24.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,899	2,030	30,191	14.87	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) CPC	2,123	2,275	48,619	21.37	33
34	TOTAL (lines 1 - 33)	84,766	87,268	$ 1,191,470 *	$ 13.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,994	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)		$ 15,994		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	144	$ 5,431	L10, C3	50
51	Licensed Practical Nurses	1,062	32,629	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,206	$ 38,060 #		53

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adam Pullen	Administrator	0	$ 53,421
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,421

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 85,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Krueger & Co.	Accounting Fees	$ 2,726
Mediacom	Computer Services	1,588
E-Health Data Solutions	Computer Services	2,221
Allscripts	Computer Services	1,949
Coles County Sheriff	Filing Fees	30
Moultrie County Circuit Clerk	Filing Fees	50
Dept of Health & Human Svcs.	Filing Fees	20
Coles County Clerk	Filing Fees	34
Illinois Secretary of State	Filing Fees	35
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,653

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,859
Unemployment Compensation Insurance	36,909
FICA Taxes	86,442
Employee Health Insurance	4,089
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,265
Employee Retirement	774
Home Office Allocation	15,041
TOTAL (agree to Schedule V, line 22, col.8)	$ 196,379

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	959
Health Care Worker Background Check	
(Indicate # of checks performed 63.1)	
Patient Background Checks	631
Miscellaneous Licenses & Permits	159
Miscellaneous Dues & Subscriptions	1,840
Home Office Allocation	176
Less: Public Relations Expense	(133)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	25
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25

**See instructions.

Eastview Terrace
0053009
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		8,653
Home Office Allocation		
Lexis Nexis	Legal	7
GoffWilson	Legal	440
Illinois Secretary of State	Legal	40
Bank of America	Legal	133
Healthcare Resources International	Legal	79
Miscellaneous	Legal	17
Addy, Bush	Legal	11
Hall, Rustom, and Fritz	Legal	13
Black, Hedin, Ballard	Legal	23
SmithAmundsen	Legal	23
CliftonLarson Allen	Accountants	934
Ginoli & Co.	Accountants	857
Miscellaneous	Computer Services	17
Odessian LLC	Computer Services	6
Optimizer	Computer Services	37
Allpayer Exchange	Computer Services	12
CCH	Computer Services	20
Prism Software	Computer Services	60
Macquarie Technology Services	Computer Services	52
Advanced Answers on Demand	Computer Services	2,770
Stratus Networks	Computer Services	365
Kemper Technology	Computer Services	1,081
AT&T	Computer Services	5
Ability Network	Computer Services	418
Barracuda	Computer Services	96

CIAN	Computer Services	113
Comcast	Computer Services	29
Emdeon	Computer Services	74
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	5
Better Banks	Other Prof Fees	3
David Budde	Other Prof Fees	32
All Scripts	Other Prof Fees	22
Miscellaneous	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		16,455

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $1707.10**

(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. $ **16,031** 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. $ **143,854**
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. $ **1,713**

(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. $ **94**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adqequate 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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Eastview Terrace** **02:44 PM** **5/28/2015**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-117,723	equal to	-117,723	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	81,393	equal to	81,393	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	23,864	equal to	23,864	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	1,289	equal to	1,289	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	48,161	equal to	48,161	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,441	equal to	6,441	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	115,309	equal to	115,309	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	43,771	equal to	43,771	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	572,520	equal to	572,520	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,103,316	equal to	1,103,316	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	365,251	equal to	365,251	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	147,970	equal to	147,970	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	168,391	equal to	168,391	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	143,854	equal to	143,854	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	805,329	equal to	805,329	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,544	equal to	21,544	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	24,942	equal to	24,942	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	134,165	equal to	134,165	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,541	equal to	29,541	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	90,975	equal to	90,975	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	1,362	equal to	1,362	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	53,421	equal to	53,421	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,191	equal to	30,191	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,191,470	equal to	1,138,049	53,421	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	42,054	< or = to	42,157	-103	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	22,858	-22,858	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	53,421	equal to	53,421	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	85,000	equal to	85,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	8,653	equal to	8,653	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	196,379	equal to	196,379	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,612	equal to	7,612	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	25	equal to	25	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	143,854	equal to	143,854	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,012	equal to	1,378	-366	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	89,290	equal to	89,290	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,564,450	equal to	1,564,450	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	23,448	equal to	23,448	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	100,000	equal to	100,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,483,010	equal to	1,483,010	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	385,247	equal to	385,247	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	840,853	equal to	840,853	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	15,337	equal to	15,337	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	274,462	equal to	274,462	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..9	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,597,929	equal to	2,597,929	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 5/28/2015 02:44:13 PM

HSA Number: 4 Name: **Eastview Terrace**

Cost report period From: 1/1/14 To: 12/31/14 Base Number: 468

If this is an ICF/DD 16 facility, enter a 1 in cell C6 N

Licensed bed days: 22,995 Occupancy: 18,796 Pct. of occupancy: 81.74%

Illinois Public Aid Support Rate: $

Genl Services Salary/Wage:	256,043	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage:	30,191	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage:	1,138,049	Col 1, Line 44 ---Audit Adj:	
Employee Benefits:	196,379	Col 8, Line 22 ---Audit Adj:	
Total General Services:	502,200	Col 8, Line 8 ---Audit Adj:	
Total General Admin:	431,604	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

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

STEP II Adjust Support Service Costs for Inflation

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

A. Base Number Calculation

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

Beginning Month + Ending Month =	13	divided by 2 =
Beginning Day + Ending Day =	32	divided by 60.8 =
Beginning Year + Ending Year =	228	multiplied by 6 =

Sum of the three lines
Subtract from the sum

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

B. Select the Appropriate Inflation Multipliers

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

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

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

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

Updated General Services Cost

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

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

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

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

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

CALCULATED PER DIEM SUPPORT COSTS

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

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

Support Costs per Diem

OR

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

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

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

Support Costs Per Diem

STEP IV Calculate Support Rate

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

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

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

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

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

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

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

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

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

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

75th Percentile is
35th Percentile is

$256,043
$1,138,049
22.4984%
$196,379

$44,182
$502,200
$546,382

$30,191
$1,138,049
2.6529%

Table I
Inflation Multipliers

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

Table II
SupportRate percentiles by HSA

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

Table II (For ICF
SupportRate per

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

	$196,379
	$5,210
	$431,604
	$196,379
	$240,435
	6.5
	0.526315789
	1368
	1375.026316
	907.00
	468
	1
	1
	$546,382
	1
	$546,382

$240,435	
1	
	$240,435
	$786,817
$40.02	
$786,817	
18,796	
$41.86	
22,995	
0.93	
21,385	
18,796	
2,589	
863	
18,796	
19,659	

$786,817
19659

$40.02

$47.44
$40.02

$7.42

0.5

$3.71

$40.02

43.73

$47.44
$40.02

$7.42

0.5	
$3.71	
3.795	
$3.710	
$40.02	
$43.73	
$43.73	
$47.44	
$39.95	

F/DD 16 Facilities)
rcentiles by HSA
Not updated with current figures

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

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	134,165	16,826	0	150,991	0	150,991	6,373	157,364
2. Food Purchase	0	164,511	0	164,511	0	164,511	-79,367	85,144
3. Housekeeping	90,975	18,182	0	109,157	0	109,157	39	109,196
4. Laundry	1,362	12,194	0	13,556	0	13,556	0	13,556
5. Heat and Other Utilities	0	0	71,956	71,956	0	71,956	239	72,195
6. Maintenance	29,541	13,359	19,449	62,349	0	62,349	2,396	64,745
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	256,043	225,072	91,405	572,520	0	572,520	-70,320	502,200
9. Medical Director	0	0	12,000	12,000	0	12,000	23	12,023
10. Nursing & Medical Records	805,329	59,118	42,157	906,604	0	906,604	-2,206	904,398
10a. Therapy	0	37	115,272	115,309	0	115,309	0	115,309
11. Activities	21,544	49	22,858	44,451	0	44,451	-94	44,357
12. Social Services	24,942	10	0	24,952	0	24,952	0	24,952
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	851,815	59,214	192,287	1,103,316	0	1,103,316	-2,277	1,101,039
17. Administrative	0	0	85,000	85,000	0	85,000	-31,579	53,421
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,653	8,653	0	8,653	7,802	16,455
20. Fees, Subscriptions & Promotion	0	0	7,569	7,569	0	7,569	43	7,612
21. Clerical & General Office	30,191	5,606	12,803	48,600	0	48,600	70,564	119,164
22. Employee Benefits & Payroll	0	0	181,338	181,338	0	181,338	15,041	196,379
23. Inservice Training & Education	0	0	0	0	0	0	29	29
24. Travel and Seminar	0	0	0	0	0	0	25	25
25. Other Admin. Staff Trans	0	0	3,411	3,411	0	3,411	3,870	7,281
26. Insurance-Prop.Liab.Malpractice	0	0	30,680	30,680	0	30,680	558	31,238
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,191	5,606	329,454	365,251	0	365,251	66,353	431,604
29. Total General Administrative	1,138,049	289,892	613,146	2,041,087	0	2,041,087	-6,244	2,034,843
30. Depreciation	0	0	45,731	45,731	0	45,731	2,430	48,161
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	1,289	1,289
32. Interest	0	0	73,099	73,099	0	73,099	8,294	81,393
33. Real Estate	0	0	23,642	23,642	0	23,642	222	23,864

34.	Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35.	Rent - Equipment & Vehicles		0	0	5,498	5,498	0	5,498	943	6,441
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	147,970	147,970	0	147,970	13,178	161,148
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	43,734	0	43,734	0	43,734	0	43,734
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	143,854	143,854	0	143,854	0	143,854
43.	Other (specify):*		0	209	124,448	124,657	0	124,657	-124,657	0
44.	Total Special Cost Ce		0	43,943	268,302	312,245	0	312,245	-124,657	187,588
45.	Grand Total		1,138,049	333,835	1,029,418	2,501,302	0	2,501,302	-117,723	2,383,579

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	85,780	85,780
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	433,230	433,230
4. Supply Inventory	12,293	12,293
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,140	27,140
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	600,222	600,222
9. Other (specify):	0	0
10. Total current assets	1,158,665	1,158,665
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	114,270	100,000
14. Buildings, at Historical Cost	982,565	991,368
15. Leasehold Improvements, Historical Cost	470,035	491,642
16. Equipment, at Historical Cost	388,392	385,247
17. Accumulated Depreciation (book methods)	-836,667	-840,853
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	320,669	320,669
23. other (specify):	0	0
24. Total Long-Term Assets	1,439,264	1,448,073
25. Total Assets	2,597,929	2,606,738
CURRENT LIABILITIES		
26. Accounts Payable	724,916	724,916
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	74,209	74,209
31. Accrued Taxes Payable	34,152	34,152
32. Accrued Real Estate Taxes	23,448	23,448
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	52,317	52,317

37. Other Current Liabilities (specify):	108,447	108,447
38. Total Current Liabilities	1,017,489	1,017,489
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,564,450	1,564,450
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	653	653
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,565,103	1,565,103
46.Total Liabilities	2,582,592	2,582,592
47.Total Equity	15,337	24,146
48.Total Liabilities and Equity	2,597,929	2,606,738

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,585,095
2. Discounts and Allowances for all Levels	-211,278
Subtotal - Inpatient Care	2,373,817
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	230,800
7. Oxygen	0
Subtotal - Anciliary Revenue	230,800
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,713
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	80,410
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	6,230
21. Other Medical Services	2,579
22. Laundry	0
Subtotal - Other Operating Revenue	90,932
24. Contributions	0
25. Interest and Other Investments Income	2
Subtotal - Non-Operating Revenue	2
27. Other Revenue (specify):	0
28. Other Revenue (specify):	80,213
Subtotal - Other Revenue	80,213
30. Total Revenue	2,775,764
31. General Services	489,552
32. Health Care	882,613
33. General Administration	464,082
34. Ownership	152,205

35.	Special Cost Centers	127,562
35.	Provider Participation Fee	117,603
37.	Other	0
40.	Total Expenses	2,233,617
41.	Income Before Income Taxes	542,147
42.	Income Taxes	0
43.	Net Income or Loss for the Year	542,147