



Facility Name & ID Number Eastview Terrace

# 0053009 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,095	2,999	1,131	18,225	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,095	2,999	1,131	18,225	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.26%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

Meals for Inmates

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 63 and days of care provided 1,081

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	137,263	12,058		149,321		149,321	4,091	153,412		1
2	Food Purchase		128,878		128,878		128,878	(2,055)	126,823		2
3	Housekeeping	112,247	11,843		124,090		124,090	62	124,152		3
4	Laundry		8,894	41,184	50,078		50,078		50,078		4
5	Heat and Other Utilities			69,901	69,901		69,901	215	70,116		5
6	Maintenance	32,358	3,782	22,429	58,569		58,569	1,933	60,502		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	281,868	165,455	133,514	580,837		580,837	4,246	585,083		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	776,492	101,755	61,648	939,895		939,895	(2,654)	937,241		10
10a	Therapy			168,927	168,927		168,927		168,927		10a
11	Activities	23,001	50	22,815	45,866		45,866	(1,483)	44,383		11
12	Social Services	26,524			26,524		26,524		26,524		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	826,017	101,805	265,390	1,193,212		1,193,212	(4,137)	1,189,075		16
	<b>C. General Administration</b>										
17	Administrative			225,100	225,100		225,100	(167,100)	58,000		17
18	Directors Fees										18
19	Professional Services			7,245	7,245		7,245	41,088	48,333		19
20	Dues, Fees, Subscriptions & Promotions			2,534	2,534		2,534	(222)	2,312		20
21	Clerical & General Office Expenses	28,224	2,619	7,848	38,691		38,691	43,907	82,598		21
22	Employee Benefits & Payroll Taxes			128,948	128,948		128,948	19,807	148,755		22
23	Inservice Training & Education							122	122		23
24	Travel and Seminar							61	61		24
25	Other Admin. Staff Transportation			279	279		279	2,932	3,211		25
26	Insurance-Prop.Liab.Malpractice			28,138	28,138		28,138	777	28,915		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	28,224	2,619	400,092	430,935		430,935	(58,628)	372,307		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,136,109	269,879	798,996	2,204,984		2,204,984	(58,519)	2,146,465		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 &amp; ID Number

Eastview Terrace

#0053009

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			54,264	54,264		54,264	9,184	63,448			30
31	Amortization of Pre-Op. & Org.							94	94			31
32	Interest			74,113	74,113		74,113	7,905	82,018			32
33	Real Estate Taxes			24,380	24,380		24,380	235	24,615			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,848	12,848		12,848	1,243	14,091			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			165,605	165,605		165,605	18,661	184,266			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,253		29,253		29,253		29,253			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,609	137,609		137,609		137,609			42
43	Other (specify):*			28,025	28,025		28,025	(28,025)				43
44	<b>TOTAL Special Cost Centers</b>		29,253	165,634	194,887		194,887	(28,025)	166,862			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,136,109	299,132	1,130,235	2,565,476		2,565,476	(67,883)	2,497,593			45

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



Eastview Terrace

ID# 0053009

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,199)	43	1
2	X-Rays-Part A	(2,099)	43	2
3	Offset of Transportation Income	(1,483)	11	3
4	Offset of Office Supplies Income	(127)	21	4
5	Offset of Chamber of Commerce Dues	(318)	20	5
6	Disallowed Special Events	(654)	43	6
7	Offset of Nursing Supplies Income	(2,711)	10	7
8	Resident Flower	(29)	43	8
9	Pet Expense	(27)	43	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
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(9,647)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,091	\$ 4,091	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	18	18	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	62	62	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	215	215	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,933	1,933	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	57	57	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	225,100	Petersen Health Care Management, Inc.	100.00%	58,000	(167,100)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	12,813	12,813	12
13	V							13
14	Total		\$ 225,100			\$ 77,189	\$ * (147,911)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs &amp; Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 96	\$	96	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	44,034		44,034	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	19,807		19,807	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	122		122	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	61		61	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,932		2,932	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	777		777	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	10,486		10,486	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	94		94	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	341		341	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	235		235	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,243		1,243	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	<b>Total</b>		\$			\$ 80,228	\$ *	80,228	39

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



Facility Name & ID Number Eastview Terrace# 0053009Report Period Beginning: 1/1/2017Ending: 12/31/2017

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health 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	4 Laundry		Petersen Health Quality, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Quality, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Quality, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		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	15 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Quality, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Quality, LLC	100.00%	28,275	28,275	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Quality, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Quality, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Quality, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Quality, LLC	100.00%	7,565	7,565	35	
36	V	33 Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Quality, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Quality, LLC	100.00%	0		38	
39	Total		\$			\$ 35,840	\$ *	35,840	39

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

Facility Name &amp; ID Number

Eastview Terrace

# 0053009

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

## VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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



Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eastview Terrace

# 0053009

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Care 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,451,714	75	\$ 325,901	\$ 376,129	18,225	\$ 4,091	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	18,225	18	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	18,225	62	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	18,225	215	4
5	6	Maintenance 50040	Resident Days	1,451,714	75	153,997	146,594	18,225	1,933	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	18,225	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	18,225	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	18,225	57	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	18,225	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	18,225	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	18,225	58,000	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	18,225	12,813	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	18,225	96	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	18,225	44,034	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	18,225	19,807	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	18,225	122	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	18,225	61	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	18,225	2,932	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	18,225	777	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	18,225	10,486	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	18,225	94	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	18,225	341	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	18,225	235	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	18,225	1,243	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 157,417	25

Facility Name & ID Number Eastview Terrace# 0053009

Report Period Beginning:

1/1/2017Ending: 2/31/2017

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Quality, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	83,607	13	\$	\$	18,225	\$	1
2	2	Food	Resident Days	83,607	13			18,225		2
3	3	Housekeeping	Resident Days	83,607	13			18,225		3
4	4	Laundry	Resident Days	83,607	13			18,225		4
5	5	Utilities	Resident Days	83,607	13			18,225		5
6	6	Maintenance	Resident Days	83,607	13			18,225		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,607	13			18,225		7
8	10	Nursing and Medical Records	Resident Days	83,607	13			18,225		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,607	13			18,225		9
10	17	Administrative	Resident Days	83,607	13			18,225		10
11	19	Professional Services	Resident Days	83,607	13	129,710		18,225	28,275	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,607	13			18,225		12
13	21	Clerical and General Office	Resident Days	83,607	13			18,225		13
14	22	Employee Benefits & Payroll	Resident Days	83,607	13			18,225		14
15	23	Inservice Training & Education	Resident Days	83,607	13			18,225		15
16	24	Travel and Seminar	Resident Days	83,607	13			18,225		16
17	25	Other Admin. Staff Transport.	Resident Days	83,607	13			18,225		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,607	13			18,225		18
19	30	Depreciation	Resident Days	83,607	13			18,225		19
20	31	Amortization	Resident Days	83,607	13			18,225		20
21	32	Interest	Resident Days	83,607	13	34,704		18,225	7,565	21
22	33	Real Estate Taxes	Resident Days	83,607	13			18,225		22
23	34	Rent-Facility and Grounds	Resident Days	83,607	13			18,225		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,607	13			18,225		24
25	TOTALS					\$ 164,414	\$		\$ 35,840	25



Facility Name & ID Number

Eastview Terrace

# 0053009

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Gemino		X	Mortgage	Varies	3/27/15	\$ 1,482,681	\$ 1,372,128	3/26/40	Varies	\$ 74,113	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,482,681	\$ 1,372,128			\$ 74,113	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(1)	10						
11									Home Office Allocation-PHQ		7,565	11						
12									Home Office Allocation-PHCM		341	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 7,905	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,482,681	\$ 1,372,128			\$ 82,018	15						

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<u>24,288</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>23,972</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(316)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>24,696</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<u>235</u>	
<b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>24,615</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>21,909</u>	8
	2013	<u>22,766</u>	9
	2014	<u>22,877</u>	10
	2015	<u>23,574</u>	11
	2016	<u>23,972</u>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**



Facility Name & ID Number Eastview Terrace

# 0053009 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

**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?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20  
3. Current Period Amortization: 94 4. Dates Incurred: 2013-2014

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	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 &amp; ID Number Eastview Terrace

# 0053009

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	2000	1976	\$ 982,565	\$	39	\$ 25,194	\$ 34,053	\$ 452,442	4
5	6	2000	1985							5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Concrete Pad	2000	2000	500		20	25	25	373	9
10	Fence	2000	2000	3,953		15			3,953	10
11	Carpet	2000	2000	503		7			503	11
12	Flooring	2001	2001	72,265		39	1,853	1,853	32,874	12
13	Remodeling	2001	2001	6,245		39	160	160	2,857	13
14	Medicare wing upgrade	2002	2002	88,301		39	2,283	2,283	38,036	14
15	Roofing	2002	2002	14,200		39	364	364	6,025	15
16	Window Balance	2004	2004	1,714		7			1,714	16
17	Grease interceptor	2005	2005	15,589		20	779	779	9,515	17
18	Sidewalks	2005	2005	4,919		20	246	246	2,979	18
19	Pipe Work	2006	2006	3,700		25	148	148	1,702	19
20	Sidewalks	2007	2007	4,420		15	295	295	3,097	20
21	Replace Exterior Storage Shed (Including Demolition of Old)	2008	2008	5,000		20	250	250	2,375	21
22	Wall Flashing-Dining Room	2011	2011	4,700		15	314	314	2,041	22
23	Sprinkler System Replacement	2011	2011	45,990		15	3,066	3,066	13,797	23
24	Parking Lot Grading	2013	2013	3,250		7	464	464	2,088	24
25	Vinyl Flooring-Hallways, Common Area, and Offices	2013	2013	29,569		25	1,182	1,182	5,319	25
26	Wandering Alert System	2014	2014	4,295		7	614	614	2,149	26
27	Block Wall Repair	2014	2014	3,800		7	543	543	1,901	27
28	Parking Lot Repaving	2014	2014	44,457		15	2,963	2,963	10,371	28
29	Roof Replacement-North and West Section	2014	2014	39,850		25	1,594	1,594	5,579	29
30	Irrigation Installation	2014	2014	4,790		15	319	319	1,117	30
31	Cabinet and Countertop Replacement	2014	2014	2,865		15	191	191	669	31
32	Window Replacement-North and West Section	2014	2014	18,199		15	1,213	1,213	4,246	32
33	Repairs and Downspout Replacement-South Section	2014	2014	16,192		15	1,079	1,079	3,777	33
34	Air Conditioner and Furnace-Rooftop	2017	2017	5,788		15	193	193	193	34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61	Land Improvements Booked		951			(951)	
62	Building Booked		25,194			(25,194)	
63	Building Improvement Booked		20,593			(20,593)	
64							
65	2017-Home Office Allocation-Building Improvements	8,336			200	200	
66	2017-Home Office Allocation-Land Improvements	767			50	50	
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 1,436,722	\$ 46,738		\$ 45,582	\$ 7,703	\$ 611,692

\*\*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:

1/1/2017

Ending:

12/31/2017

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	\$ 76,854	\$ 7,526	\$ 7,630	\$ 104	5-10 yrs.	\$ 37,619	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	287,888					287,888	73
74	Home Office Allocation			10,236	10,236			74
75	TOTALS	\$ 364,742	\$ 7,526	\$ 17,866	\$ 10,340		\$ 325,507	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)	\$ 1,929,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,264	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,448	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,184	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 965,527	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					88
89	N/A				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: 1/1/2017

Ending: 12/31/2017

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 14,091      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	<b>TOTAL</b>		\$	\$	21

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

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



**Eastview Terrace  
0053009**

**Period Beginning**      1/1/2017  
**Period End**              12/31/2017

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	10,498
Dishwasher		701
Floor Scrubber		132
Copier		1,517
Home Office Allocation		1,243
		<u>14,091</u>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,275	\$ 64,120	\$	4,275	\$ 64,120	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,360	35,397		2,360	35,397	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,627	69,410		4,627	69,410	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 prescripts				29,253		29,253	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	<b>TOTAL</b>			\$	11,262	\$ 168,927	\$ 29,253	11,262	\$ 198,180	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 &amp; ID Number Eastview Terrace

# 0053009

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,113,733	\$ 1,113,733	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 127,904 )	360,509	360,509	3
4	Supply Inventory (priced at Cost )	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,321	19,321	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,505,856	\$ 1,505,856	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114,270	100,000	13
14	Buildings, at Historical Cost	982,565	990,901	14
15	Leasehold Improvements, at Historical Cost	475,823	445,821	15
16	Equipment, at Historical Cost	393,070	393,070	16
17	Accumulated Depreciation (book methods)	(1,000,451)	(965,527)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	48,194	48,194	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,013,471	\$ 1,012,459	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,519,327	\$ 2,518,315	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 403,067	\$ 403,067	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,130	70,130	30
31	Accrued Taxes Payable (excluding real estate taxes)	80,876	80,876	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,696	24,696	32
33	Accrued Interest Payable	6,199	6,199	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	32,793	32,793	36
37	<u>Accrued Management Fees</u>	333,992	333,992	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 951,753	\$ 951,753	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,372,128	1,372,128	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,372,128	\$ 1,372,128	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,323,881	\$ 2,323,881	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 195,446	\$ 194,434	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,519,327	\$ 2,518,315	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(353,969)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Report Was Filed</b>	<b>4,986</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(348,983)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>544,429</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>544,429</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>195,446</b>	<b>24</b> *

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

Facility Name &amp; ID Number Eastview Terrace

# 0053009

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,867,875	1
2	Discounts and Allowances for all Levels	(129,153)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,738,722	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	307,191	6
7	Oxygen	165	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 307,356	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,073	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	48,605	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,091	20
21	Other Medical Services	3,736	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 59,505	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	1,483	28
28a	<u>Miscellaneous Revenue</u>	2,838	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,321	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,109,905	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	580,837	31
32	Health Care	1,193,212	32
33	General Administration	430,935	33
<b>B. Capital Expense</b>			
34	Ownership	165,605	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	57,278	35
36	Provider Participation Fee	137,609	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,565,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	544,429	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 544,429	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,120,237	44
45	Private Pay - Net Inpatient Revenue	386,584	45
46	Medicare - Net Inpatient Revenue	226,876	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	5,025	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,738,722	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:

1/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,043	2,131	\$ 45,388	\$ 21.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	908	908	25,160	27.71	3
4	Licensed Practical Nurses	12,413	12,864	290,294	22.57	4
5	CNAs & Orderlies	32,011	32,547	348,587	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,750	1,822	23,001	12.62	9
10	Activity Assistants					10
11	Social Service Workers	2,050	2,058	26,524	12.89	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,482	16.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,744	11,049	102,781	9.30	15
16	Dishwashers					16
17	Maintenance Workers	1,740	1,804	32,358	17.94	17
18	Housekeepers	10,673	10,845	112,247	10.35	18
19	Laundry					19
20	Administrator	2,080	2,080	58,000	27.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,867	1,887	28,224	14.96	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	200	200	2,996	14.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>CPC</u>	2,648	2,648	64,067	24.19	33
34	TOTAL (lines 1 - 33)	83,207	84,923	\$ 1,194,109 *	\$ 14.06	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,750	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)		\$ 16,750		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,477	\$ 56,770	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,477	\$ 56,770		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Lacy Mossman</u>	<u>Administrator</u>	<u>0</u>	\$ <u>58,000</u>	<u>Workers' Compensation Insurance</u>	\$ <u>22,082</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>19,997</u>	<u>Advertising: Employee Recruitment</u>	<u>67</u>	
				<u>FICA Taxes</u>	<u>85,181</u>	<u>Health Care Worker Background Check</u>	<u>797</u>	
				<u>Employee Health Insurance</u>	<u>625</u>	(Indicate # of checks performed <u>115</u> )		
				<u>Employee Meals</u>		<u>Miscellaneous Licenses &amp; Permits</u>	<u>400</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>1,270</u>	
				<u>Employee Relations</u>	<u>425</u>	<u>Home Office Allocation</u>	<u>96</u>	
				<u>Employee Retirement</u>	<u>638</u>			
				<u>Home Office Allocation</u>	<u>19,807</u>			
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 58,000</b>					
<b>(List each licensed administrator separately.)</b>								
<b>B. Administrative - Other</b>								
Description			Amount					
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>225,100</u>			<u>Less: Public Relations Expense</u>	<u>(318)</u>	
						<u>Non-allowable advertising</u>	( )	
						<u>Yellow page advertising</u>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 225,100</b>	<b>TOTAL (agree to Schedule V,</b>	<b>\$ 148,755</b>	<b>TOTAL (agree to Sch. V,</b>	<b>\$ 2,312</b>	
<b>(Attach a copy of any management service agreement)</b>				<b>line 22, col.8)</b>		<b>line 20, col. 8)</b>		
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>		<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Allscripts</u>	<u>Computer Services</u>		<u>888</u>			\$	<u>Out-of-State Travel</u>	\$
<u>Ability Network</u>	<u>Computer Services</u>		<u>4,248</u>					
<u>Mediacom</u>	<u>Computer Services</u>		<u>2,109</u>					
				<u>N/A</u>			<u>In-State Travel</u>	
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>61</u>
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 7,245</b>	<b>TOTAL</b>		<b>\$</b>	<b>(agree to Sch. V,</b>	
<b>(For legal fee disclosure, see page 39 of instructions)</b>							<b>line 24, col. 8)</b>	
							<b>TOTAL</b>	<b>\$ 61</b>

\* Attach copy of IMRF notifications

\*\*See instructions.



Eastview Terrace  
0053009  
Period Beginning  
Period End

1/1/2017  
12/31/2017

Schedule 21A

**XIX. SUPPORT SCHEDULE**  
**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		7,245
<b>Home Office Allocation</b>		
MusilloUnkenholt, LLC	Legal	146
Arnstein & Lehr	Legal	984
SB2	Legal	619
Miscellaneous	Legal	11
Miller Hall and Triggs	Legal	157
Smith Amundsen	Legal	61
Healthcare Resources International	Legal	109
Hunziker Law	Legal	1
Lexis Nexis	Legal	6
Baker Tilly Virchow Krause	Legal	549
Secretary of State	Legal	44
Gemino	Legal	40
CliftonLarsonAllen	Accounting	3010
Ginoli & Co.	Accounting	4319
Baker Tilly Virchow Krause	Accounting	110
Gemino	Accounting	1942
Miscellaneous	Computer Services	82
Change Healthcare	Computer Services	7
360 Networks	Computer Services	34
Matrix Care	Computer Services	3066
Stratus Networks	Computer Services	366
Kemper Technology	Computer Services	208
AT&T	Computer Services	5
Ability Network	Computer Services	226
CIAN	Computer Services	255
Comcast	Computer Services	14
CCH	Computer Services	12
Charter Communications	Computer Services	26
Allscripts	Computer Services	227
ATS	Computer Services	233
Citrix Systems	Computer Services	21
Optimizer	Other Prof Fees	41
Ankura	Other Prof Fees	660
David Budde	Other Prof Fees	31
Sargent Consulting	Other Prof Fees	12734
Alix Partners	Other Prof Fees	11345
Demonica Kemper	Other Prof Fees	27
Brad Barkley	Other Prof Fees	108
MPAC Healthcare	Other Prof Fees	16
Higgs Appraisal	Other Prof Fees	8
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		<u>49,108</u>

