

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0053009

Facility Name: Eastview Terrace

Address: 100 Eastview Place Sullivan 61951
Number City 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
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
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 1/1/2016 to 12/31/2016 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)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed)
(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: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,854</u>	<u>3,510</u>	<u>1,448</u>	<u>17,812</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,854</u>	<u>3,510</u>	<u>1,448</u>	<u>17,812</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.46%

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

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

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

Meals for Inmates

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☒ NO ☐

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

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/2000

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/2000 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 63 and days of care provided 1,115

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	
	A. General Services											
1	Dietary	130,831	10,864		141,695		141,695	3,659	145,354			1
2	Food Purchase		127,554		127,554		127,554	(2,925)	124,629			2
3	Housekeeping	116,321	11,942		128,263		128,263	64	128,327			3
4	Laundry	61	11,159	41,184	52,404		52,404		52,404			4
5	Heat and Other Utilities			64,590	64,590		64,590	213	64,803			5
6	Maintenance	34,962	6,271	26,739	67,972		67,972	1,998	69,970			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	282,175	167,790	132,513	582,478		582,478	3,009	585,487			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	802,824	85,845	35,013	923,682		923,682	(41)	923,641			10
10a	Therapy			177,754	177,754		177,754		177,754			10a
11	Activities	23,766	21	22,815	46,602		46,602	314	46,916			11
12	Social Services	21,047	22		21,069		21,069		21,069			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	847,637	85,888	247,582	1,181,107		1,181,107	273	1,181,380			16
	C. General Administration											
17	Administrative	6,563		219,400	225,963		225,963	(166,118)	59,845			17
18	Directors Fees											18
19	Professional Services			7,615	7,615		7,615	12,314	19,929			19
20	Dues, Fees, Subscriptions & Promotions			6,823	6,823		6,823	72	6,895			20
21	Clerical & General Office Expenses	32,252	3,430	13,421	49,103		49,103	42,578	91,681			21
22	Employee Benefits & Payroll Taxes			218,074	218,074		218,074	23,850	241,924			22
23	Inservice Training & Education							82	82			23
24	Travel and Seminar							40	40			24
25	Other Admin. Staff Transportation			358	358		358	3,355	3,713			25
26	Insurance-Prop.Liab.Malpractice			29,927	29,927		29,927	473	30,400			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	38,815	3,430	495,618	537,863		537,863	(83,354)	454,509			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,168,627	257,108	875,713	2,301,448		2,301,448	(80,072)	2,221,376			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			54,521	54,521		54,521	7,797	62,318			30
31	Amortization of Pre-Op. & Org.							14,816	14,816			31
32	Interest			76,078	76,078		76,078	1,588	77,666			32
33	Real Estate Taxes			24,304	24,304		24,304	217	24,521			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,412	8,412		8,412	767	9,179			35
36	Other (specify):*											36
37	TOTAL Ownership			163,315	163,315		163,315	25,185	188,500			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,261		28,261		28,261		28,261			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,856	133,856		133,856		133,856			42
43	Other (specify):*		16	18,741	18,757		18,757	(18,757)				43
44	TOTAL Special Cost Centers		28,277	152,597	180,874		180,874	(18,757)	162,117			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,168,627	285,385	1,191,625	2,645,637		2,645,637	(73,644)	2,571,993			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,991)	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	(1,642)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,065)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,653)	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	(5,076)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,621)		\$	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)	(50,023)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,023)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (73,644)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,314)	43	1
2	X-Rays-Part A	(2,149)	43	2
3	Offset of Transportation Income	314	11	3
4	Offset of Office Supplies Income	(75)	21	4
5	Offset of Chamber of Commerce Dues	(318)	20	5
6	Disallowed Special Events	(385)	43	6
7	Offset of Nursing Supplies Income	(149)	10	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,076)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace# 0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,659	0	0	0	0	0	0	0	0	0	3,659	1
2	Food Purchase	(2,991)	66	0	0	0	0	0	0	0	0	0	(2,925)	2
3	Housekeeping	0	64	0	0	0	0	0	0	0	0	0	64	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	213	0	0	0	0	0	0	0	0	0	213	5
6	Maintenance	0	1,998	0	0	0	0	0	0	0	0	0	1,998	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,991)	6,000	0	0	0	0	0	0	0	0	0	3,009	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(149)	108	0	0	0	0	0	0	0	0	0	(41)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	314	0	0	0	0	0	0	0	0	0	0	314	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	165	108	0	0	0	0	0	0	0	0	0	273	16
	C. General Administration													
17	Administrative	0	(166,118)	0	0	0	0	0	0	0	0	0	(166,118)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,317	0	2,997	0	0	0	0	0	0	0	12,314	19
20	Fees, Subscriptions & Promotions	(318)	0	390	0	0	0	0	0	0	0	0	72	20
21	Clerical & General Office Expenses	(75)	0	42,653	0	0	0	0	0	0	0	0	42,578	21
22	Employee Benefits & Payroll Taxes	0	0	23,850	0	0	0	0	0	0	0	0	23,850	22
23	Inservice Training & Education	0	0	82	0	0	0	0	0	0	0	0	82	23
24	Travel and Seminar	0	0	40	0	0	0	0	0	0	0	0	40	24
25	Other Admin. Staff Transportation	0	0	3,355	0	0	0	0	0	0	0	0	3,355	25
26	Insurance-Prop.Liab.Malpractice	0	0	473	0	0	0	0	0	0	0	0	473	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(393)	(156,801)	70,843	2,997	0	0	0	0	0	0	0	(83,354)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,219)	(150,693)	70,843	2,997	0	0	0	0	0	0	0	(80,072)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,642)	0	9,439	0	0	0	0	0	0	0	0	7,797	30
31	Amortization of Pre-Op. & Org.	0	0	0	14,816	0	0	0	0	0	0	0	14,816	31
32	Interest	(3)	0	277	1,314	0	0	0	0	0	0	0	1,588	32
33	Real Estate Taxes	0	0	217	0	0	0	0	0	0	0	0	217	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	767	0	0	0	0	0	0	0	0	767	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,645)	0	10,700	16,130	0	0	0	0	0	0	0	25,185	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(18,757)	0	0	0	0	0	0	0	0	0	0	(18,757)	43
44	TOTAL Special Cost Centers	(18,757)	0	0	0	0	0	0	0	0	0	0	(18,757)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,621)	(150,693)	81,543	19,127	0	0	0	0	0	0	0	(73,644)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,659	\$ 3,659	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	66	66	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	64	64	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	213	213	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,998	1,998	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%	108	108	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	219,400	Petersen Health Care Management, Inc.	100.00%	53,282	(166,118)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	9,317	9,317	12
13	V								13
14	Total			\$ 219,400			\$ 68,707	\$ * (150,693)	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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 390	\$ 390	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	42,653	42,653	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	23,850	23,850	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	82	82	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	40	40	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,355	3,355	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	473	473	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,439	9,439	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	277	277	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	217	217	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	767	767	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			\$			\$ 81,543	\$ * 81,543	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	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%	2,997	2,997	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%	14,816	14,816	34
35	V	32	Interest		Petersen Health Quality, LLC	100.00%	1,314	1,314	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			\$			\$ 19,127	\$ * 19,127	39

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

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	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 Busin	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

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

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

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

Facility Name & ID Number Eastview Terrace# 0053009

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	17,812	\$ 3,659	1
2	2	Food	Resident Days	75	5,673	0	17,812	66	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	17,812	64	3
4	5	Utilities	Resident Days	75	18,209	0	17,812	213	4
5	6	Maintenance	Resident Days	75	170,632	137,057	17,812	1,998	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	17,812	0	6
7	9	Medical Director	Resident Days	75	0	0	17,812	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	17,812	108	8
9	10A	Therapy	Resident Days	75	0	0	17,812	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	17,812	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	17,812	53,282	11
12	19	Professional Services	Resident Days	75	795,918	0	17,812	9,317	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	17,812	390	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	17,812	42,653	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	17,812	23,850	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	17,812	82	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	17,812	40	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	17,812	3,355	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	17,812	473	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	17,812	0	20
21	30	Depreciation	Resident Days	75	806,271	0	17,812	9,439	21
22	32	Interest	Resident Days	75	23,686	0	17,812	277	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	17,812	217	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	17,812	767	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 150,250	25

Facility Name & ID Number Eastview Terrace# 0053009

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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 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

	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	83,584	5	\$	\$	17,812	\$	1
2	2	Food	Resident Days	83,584	5			17,812		2
3	3	Housekeeping	Resident Days	83,584	5			17,812		3
4	4	Laundry	Resident Days	83,584	5			17,812		4
5	5	Utilities	Resident Days	83,584	5			17,812		5
6	6	Maintenance	Resident Days	83,584	5			17,812		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,584	5			17,812		7
8	10	Nursing and Medical Records	Resident Days	83,584	5			17,812		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,584	5			17,812		9
10	17	Administrative	Resident Days	83,584	5			17,812		10
11	19	Professional Services	Resident Days	83,584	5	14,064		17,812	2,997	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,584	5			17,812		12
13	21	Clerical and General Office	Resident Days	83,584	5			17,812		13
14	22	Employee Benefits & Payroll	Resident Days	83,584	5			17,812		14
15	23	Inservice Training & Education	Resident Days	83,584	5			17,812		15
16	24	Travel and Seminar	Resident Days	83,584	5			17,812		16
17	25	Other Admin. Staff Transport.	Resident Days	83,584	5			17,812		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,584	5			17,812		18
19	27	Mgmt. Allocation of Benefits	Resident Days	83,584	5			17,812		19
20	31	Amortization	Resident Days	83,584	5	69,527		17,812	14,816	20
21	32	Interest	Resident Days	83,584	5	6,168		17,812	1,314	21
22	33	Real Estate Taxes	Resident Days	83,584	5			17,812		22
23	34	Rent-Facility and Grounds	Resident Days	83,584	5			17,812		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,584	5			17,812		24
25	TOTALS					\$ 89,759	\$		\$ 19,127	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Gemino		X	Mortgage	Varies	3/27/15	\$ 1,482,681	\$ 1,419,097	3/26/40	Varies	\$ 76,078	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,482,681	\$ 1,419,097			\$ 76,078	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(3)	10	
11								Home Office Allocation-PHQ		1,314		11	
12								Home Office Allocation-PHCM		277		12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 1,588	14	
15	TOTALS (line 9+line14)						\$ 1,482,681	\$ 1,419,097			\$ 77,666	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

[illegible]

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0053009

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 08-08-01-202-037	Long-Term Care Facility	\$ 23,574.22	\$ 23,574.22
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 23,574.22	\$ 23,574.22

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082

B. General Construction Type: Exterior BrickFrame SteelNumber 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.(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? YESNO

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: 14,816

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		2000	1976	\$ 982,565	\$	39	\$ 25,194	\$ 25,194	\$ 427,248	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete Pad		2000		500		20	25	25	348	9
10	Fence		2000		3,953		15			3,953	10
11	Carpet		2000		503		7			503	11
12	Flooring		2001		72,265		39	1,853	1,853	31,021	12
13	Remodeling		2001		6,245		39	160	160	2,697	13
14	Medicare wing upgrade		2002		88,301		39	2,283	2,283	35,753	14
15	Roofing		2002		14,200		39	364	364	5,661	15
16	Window Balance		2004		1,714		7			1,714	16
17	Grease interceptor		2005		15,589		20	779	779	8,736	17
18	Sidewalks		2005		4,919		20	246	246	2,733	18
19	Pipe Work		2006		3,700		25	148	148	1,554	19
20	Sidewalks		2007		4,420		15	295	295	2,802	20
21	Replace Exterior Storage Shed (Including Demolition of Old)		2008		5,000		20	250	250	2,125	21
22	Wall Flashing-Dining Room		2011		4,700		15	314	314	1,727	22
23	Sprinkler System Replacement		2011		45,990		15	3,066	3,066	10,731	23
24	Parking Lot Grading		2013		3,250		7	464	464	1,624	24
25	Vinyl Flooring-Hallways, Common Area, and Offices		2013		29,569		25	1,182	1,182	4,137	25
26	Wandering Alert System		2014		4,295		7	614	614	1,535	26
27	Block Wall Repair		2014		3,800		7	543	543	1,358	27
28	Parking Lot Repaving		2014		44,457		15	2,963	2,963	7,408	28
29	Roof Replacement-North and West Section		2014		39,850		25	1,594	1,594	3,985	29
30	Irrigation Installation		2014		4,790		15	319	319	798	30
31	Cabinet and Countertop Replacement		2014		2,865		15	191	191	478	31
32	Window Replacement-North and West Section		2014		18,199		15	1,213	1,213	3,033	32
33	Repairs and Downspout Replacement-South Section		2014		16,192		15	1,079	1,079	2,698	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62			951			(951)		62
63			25,194			(25,194)		63
64			20,303			(20,303)		64
65								65
66		7,864			189	189		66
67		724			47	47		67
68								68
69								69
70		\$ 1,430,419	\$ 46,448		\$ 45,375	\$ (1,073)	\$ 566,360	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$75,931	\$7,528	\$7,396	\$(132)	5-10 yrs.	\$33,543	71
72	Current Year Purchases	4,821	545	344	(201)	7 yrs.	344	72
73	Fully Depreciated Assets	283,990					283,990	73
74	Home Office Allocation			9,203	9,203			74
75	TOTALS	\$364,742	\$8,073	\$16,943	\$8,870		\$317,877	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,923,489	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,521	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$62,318	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$7,797	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$912,565	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			93
94	N/A		94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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: YESNO Terms: *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$ 9,179Description: 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	N/A				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 1/1/2016
Period End 12/31/2016

Schedule 14A

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

Medical Equipment	\$	5,953
Dishwasher		701
Copier		1,758
Home Office Allocation		<u>767</u>
		<u><u>9,179</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			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	\$	4,222	\$ 63,332	\$	4,222	\$ 63,332	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,390	20,845		1,390	20,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,238	93,577		6,238	93,577	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				28,261		28,261	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			\$	11,850	\$ 177,754	\$ 28,261	11,850	\$ 206,015	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 585,557	\$ 585,557	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 128,332)	513,231	513,231	3
4	Supply Inventory (priced at Cost)	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,752	17,752	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,128,833	\$ 1,128,833	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	990,429	14
15	Leasehold Improvements, at Historical Cost	470,035	439,990	15
16	Equipment, at Historical Cost	393,070	393,070	16
17	Accumulated Depreciation (book methods)	(946,188)	(912,565)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	66,593	66,593	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,080,345	\$ 1,077,517	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,209,178	\$ 2,206,350	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 528,397	\$ 528,397	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,748	69,748	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,671	30,671	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,872	47,872	32
33	Accrued Interest Payable	5,789	5,789	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	82,860	82,860	36
37	Accrued Management Fees	322,849	322,849	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,088,186	\$ 1,088,186	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,419,097	1,419,097	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	55,864	55,864	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,474,961	\$ 1,474,961	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,563,147	\$ 2,563,147	46
47	TOTAL EQUITY(page 18, line 24)	\$ (353,969)	\$ (356,797)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,209,178	\$ 2,206,350	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (762,952)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(14,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (776,952)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	422,983	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)	\$ 422,983	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (353,969)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,871,719	1
2	Discounts and Allowances for all Levels	(191,223)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,680,496	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	321,133	6
7	Oxygen	327	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 321,460	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	2,991	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	54,265	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,825	20
21	Other Medical Services	4,670	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 66,751	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(314)	28
28a	<u>Miscellaneous Revenue</u>	224	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (90)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,068,620	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	582,478	31
32	Health Care	1,181,107	32
33	General Administration	537,863	33
	B. Capital Expense		
34	Ownership	163,315	34
	C. Ancillary Expense		
35	Special Cost Centers	47,018	35
36	Provider Participation Fee	133,856	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,645,637	40
41	Income before Income Taxes (line 30 minus line 40)**	422,983	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 422,983	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,895,054	44
45	Private Pay - Net Inpatient Revenue	494,465	45
46	Medicare - Net Inpatient Revenue	227,168	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	63,809	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,680,496	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:

1/1/2016

Ending:

12/31/2016

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	2,070	2,232	\$ 53,144	\$ 23.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,529	1,614	38,902	24.10	3
4	Licensed Practical Nurses	13,972	14,440	299,896	20.77	4
5	CNAs & Orderlies	31,641	32,125	345,343	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,845	1,909	23,766	12.45	9
10	Activity Assistants					10
11	Social Service Workers	1,546	1,578	21,047	13.34	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,627	16.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,404	10,529	97,204	9.23	15
16	Dishwashers					16
17	Maintenance Workers	1,944	1,944	34,962	17.98	17
18	Housekeepers	12,275	12,532	116,321	9.28	18
19	Laundry	7	7	61	8.71	19
20	Administrator	2,080	2,080	53,282	25.62	20
21	Assistant Administrator	260	260	6,563	25.24	21
22	Other Administrative					22
23	Office Manager	1,965	2,026	32,252	15.92	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CPC</u>	2,213	2,213	65,539	29.62	33
34	TOTAL (lines 1 - 33)	85,831	87,569	\$ 1,221,909 *	\$ 13.95	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		\$	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,917	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)		\$ 15,917		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	807	\$ 29,511	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	807	\$ 29,511		53

STATE OF ILLINOIS

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Lacy Mossman	Administrator	0	\$ 53,282	Workers' Compensation Insurance	\$ 88,739	IDPH License Fee	\$ 3,980		
Amanda Yoder	Asst. Administrator	0	6,563	Unemployment Compensation Insurance	34,002	Advertising: Employee Recruitment	50		
				FICA Taxes	87,310	Health Care Worker Background Check			
				Employee Health Insurance	4,849	(Indicate # of checks performed 40)	237		
				Employee Meals		Patient Background Checks 23	238		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,000		
				Employee Relations	2,610	Miscellaneous Dues & Subscriptions	1,318		
				Employee Retirement	564	Home Office Allocation	390		
				Home Office Allocation	23,850				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 59,845						
B. Administrative - Other									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 219,400			Less: Public Relations Expense	(318)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 219,400	TOTAL (agree to Schedule V, line 22, col.8)	\$ 241,924	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,895		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Honkamp Krueger & Co.	Accounting Fees		\$ 1,840				Out-of-State Travel	\$	
Mediacom	Computer Services		1,683						
E-Health Data Solutions	Computer Services		2,941	N/A					
Allscripts	Computer Services		961				In-State Travel		
Ability Network	Computer Services		102						
ProTitle USA	Legal Fees		88						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(For legal fee disclosure, see page 39 of instructions)			\$ 7,615						

* Attach copy of IMRF notifications

**See instructions.

Eastview Terrace
0053009
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,615
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	42
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	72
Healthcare Resources International	Legal	359
Hunziker Law	Legal	86
Lexis Nexis	Legal	7
Gemino	Legal	266
Illinois Secretary of State	Legal	53
Peoria County Recorder	Legal	22
CliftonLarson Allen	Accountants	473
Ginoli & Co.	Accountants	3,776
Miscellaneous	Computer Services	47
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3,280
Stratus Networks	Computer Services	334
Kemper Technology	Computer Services	220
AT&T	Computer Services	5
Ability Network	Computer Services	1,399
CIAN	Computer Services	167
Comcast	Computer Services	27
CCH	Computer Services	11
Charter Communications	Computer Services	32
Allscripts	Computer Services	488
ATS	Computer Services	220
Allpayer Exchange	Computer Services	11
Optimizer	Other Prof Fees	34
Ankura	Other Prof Fees	255
David Budde	Other Prof Fees	29
Bruner, Cooper, Zuck	Other Prof Fees	74
Marotta, Gund, Budd, Dzerda	Other Prof Fees	458
Professional Software and Services	Other Prof Fees	18
Hughes Valuation Services	Other Prof Fees	23
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)	<u><u>19,929</u></u>
--	----------------------

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>IHCA-\$1,000</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7 yrs.</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>22,971</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>133,856</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>2,991</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>Yes</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>0</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u>
d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>Ginoli and Company</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>No</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
|---|--|

RECONCILIATION REPORT			Eastview Terrace		09:57 AM		7/7/2017						
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	-73,644	equal to	-73,644	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	77,666	equal to	77,666	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	24,521	equal to	24,521	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	14,816	equal to	14,816	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	62,318	equal to	62,318	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	9,179	equal to	9,179	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	177,754	equal to	177,754	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	28,261	equal to	28,261	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	582,478	equal to	582,478	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,181,107	equal to	1,181,107	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	537,863	equal to	537,863	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	163,315	equal to	163,315	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	47,018	equal to	47,018	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	133,856	equal to	133,856	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	802,824	equal to	802,824	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	23,766	equal to	23,766	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	21,047	equal to	21,047	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	130,831	equal to	130,831	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	34,962	equal to	34,962	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	116,321	equal to	116,321	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	61	equal to	61	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	59,845	equal to	59,845	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	32,252	equal to	32,252	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	1,221,909	equal to	1,168,627	53,282	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	33,428	< or = to	35,013	-1,585	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	22,815	-22,815	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.	59,845	equal to	59,845	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	219,400	equal to	219,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	7,615	equal to	7,615	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	241,924	equal to	241,924	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	6,895	equal to	6,895	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	40	equal to	40	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	133,856	equal to	133,856	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	1,115	equal to	1,448	-333	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-50,023	equal to	-50,023	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	1,419,097	equal to	1,419,097	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	47,872	equal to	47,872	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	1,430,419	equal to	1,430,419	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	393,070	equal to	393,070	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	912,565	equal to	912,565	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-353,969	equal to	-353,969	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	422,983	equal to	422,983	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..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,209,178	equal to	2,209,178	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	130,831	10,864	0	141,695	0	141,695	3,659	145,354
2. Food Purchase	0	127,554	0	127,554	0	127,554	-2,925	124,629
3. Housekeeping	116,321	11,942	0	128,263	0	128,263	64	128,327
4. Laundry	61	11,159	41,184	52,404	0	52,404	0	52,404
5. Heat and Other Utilities	0	0	64,590	64,590	0	64,590	213	64,803
6. Maintenance	34,962	6,271	26,739	67,972	0	67,972	1,998	69,970
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	282,175	167,790	132,513	582,478	0	582,478	3,009	585,487
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	802,824	85,845	35,013	923,682	0	923,682	-41	923,641
10a. Therapy	0	0	177,754	177,754	0	177,754	0	177,754
11. Activities	23,766	21	22,815	46,602	0	46,602	314	46,916
12. Social Services	21,047	22	0	21,069	0	21,069	0	21,069
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	847,637	85,888	247,582	1,181,107	0	1,181,107	273	#####
17. Administrative	6,563	0	219,400	225,963	0	225,963	-166,118	59,845
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,615	7,615	0	7,615	12,314	19,929
20. Fees, Subscriptions & Promotion	0	0	6,823	6,823	0	6,823	72	6,895
21. Clerical & General Office	32,252	3,430	13,421	49,103	0	49,103	42,578	91,681
22. Employee Benefits & Payroll	0	0	218,074	218,074	0	218,074	23,850	241,924
23. Inservice Training & Education	0	0	0	0	0	0	82	82
24. Travel and Seminar	0	0	0	0	0	0	40	40
25. Other Admin. Staff Trans	0	0	358	358	0	358	3,355	3,713
26. Insurance-Prop.Liab.Malpractice	0	0	29,927	29,927	0	29,927	473	30,400
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	38,815	3,430	495,618	537,863	0	537,863	-83,354	454,509
29. Total General Administrative	1,168,627	257,108	875,713	2,301,448	0	2,301,448	-80,072	#####
30. Depreciation	0	0	54,521	54,521	0	54,521	7,797	62,318
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	14,816	14,816
32. Interest	0	0	76,078	76,078	0	76,078	1,588	77,666
33. Real Estate	0	0	24,304	24,304	0	24,304	217	24,521
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	8,412	8,412	0	8,412	767	9,179
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	163,315	163,315	0	163,315	25,185	188,500
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	28,261	0	28,261	0	28,261	0	28,261
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	133,856	133,856	0	133,856	0	133,856
43. Other (specify):*	0	16	18,741	18,757	0	18,757	-18,757	0
44. Total Special Cost Ce	0	28,277	152,597	180,874	0	180,874	-18,757	162,117
45. Grand Total	1,168,627	285,385	1,191,625	2,645,637	0	2,645,637	-73,644	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	585,557	585,557
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	513,231	513,231
4. Supply Inventory	12,293	12,293
5. Short-Term Investments	0	0
6. Prepaid Insurance	17,752	17,752
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,128,833	1,128,833
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	990,429
15. Leasehold Improvements, Historical Cost	470,035	439,990
16. Equipment, at Historical Cost	393,070	393,070
17. Accumulated Depreciation (book methods)	-946,188	-912,565
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	66,593	66,593
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,080,345	1,077,517
25. Total Assets	2,209,178	2,206,350
CURRENT LIABILITIES		
26. Accounts Payable	528,397	528,397
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	69,748	69,748
31. Accrued Taxes Payable	30,671	30,671
32. Accrued Real Estate Taxes	47,872	47,872
33. Accrued Interest Payable	5,789	5,789
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	82,860	82,860
37. Other Current Liabilities (specify):	322,849	322,849
38. Total Current Liabilities	1,088,186	1,088,186
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,419,097	1,419,097
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	55,864	55,864
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,474,961	1,474,961
46.Total Liabilities	2,563,147	2,563,147
47.Total Equity	-353,969	-356,797
48.Total Liabilities and Equity	2,209,178	2,206,350

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,871,719
2. Discounts and Allowances for all Levels	-191,223
Subtotal - Inpatient Care	2,680,496
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	321,133
7. Oxygen	327
Subtotal - Anciliary Revenue	321,460
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	2,991
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	54,265
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	4,825
21. Other Medical Services	4,670
22. Laundry	0
Subtotal - Other Operating Revenue	66,751
24. Contributions	0
25. Interest and Other Investments Income	3
Subtotal - Non-Operating Revenue	3
27. Other Revenue (specify):	-314
28. Other Revenue (specify):	224
Subtotal - Other Revenue	-90
30. Total Revenue	3,068,620
31. General Services	636,595
32. Health Care	1,182,698
33. General Administration	440,948
34. Ownership	145,981
35. Special Cost Centers	176,660
35. Provider Participation Fee	134,873
37. Other	0
40. Total Expenses	2,717,755
41. Income Before Income Taxes	350,865
42. Income Taxes	0
43. Net Income or Loss for the Year	350,865