

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0056507</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Eastview Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>100 Eastview Place</u> <u>Sullivan</u> <u>61951</u>			
Number City Zip Code			
County: <u>Moultrie</u>			
Telephone Number: <u>(217) 728-7367</u> Fax # <u>(217) 728-8405</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>02/01/00</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mike Kocher</u>		Telephone Number: <u>(309)689-5850</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Mark Petersen</u>	
		(Title) <u>Chief Executive Officer</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		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

0056507 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,192</u>	<u>2,670</u>	<u>1,062</u>	<u>17,924</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>14,192</u>	<u>2,670</u>	<u>1,062</u>	<u>17,924</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.95%

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 992

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eastview Terrace # 0056507 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	148,319	19,652	406	168,377		168,377	4,773	173,150			1
2	Food Purchase		140,616		140,616		140,616	(1,815)	138,801			2
3	Housekeeping	105,944	20,941		126,885		126,885	92	126,977			3
4	Laundry		11,603	41,184	52,787		52,787		52,787			4
5	Heat and Other Utilities			65,365	65,365		65,365	326	65,691			5
6	Maintenance	37,411	5,246	25,939	68,596		68,596	2,866	71,462			6
7	Other (specify):*											7
8	TOTAL General Services	291,674	198,058	132,894	622,626		622,626	6,242	628,868			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	970,814	62,492	26,615	1,059,921		1,059,921	873	1,060,794			10
10a	Therapy			193,848	193,848		193,848		193,848			10a
11	Activities	26,272	22,815		49,087		49,087	(217)	48,870			11
12	Social Services	32,877			32,877		32,877		32,877			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,029,963	85,307	232,463	1,347,733		1,347,733	656	1,348,389			16
	C. General Administration											
17	Administrative	67,500		163,600	231,100		231,100	(137,058)	94,042			17
18	Directors Fees											18
19	Professional Services			11,012	11,012		11,012	17,650	28,662			19
20	Dues, Fees, Subscriptions & Promotions			2,775	2,775		2,775	2,443	5,218			20
21	Clerical & General Office Expenses	32,055	1,546	7,276	40,877		40,877	29,579	70,456			21
22	Employee Benefits & Payroll Taxes			153,218	153,218		153,218	8,124	161,342			22
23	Inservice Training & Education							49	49			23
24	Travel and Seminar							15	15			24
25	Other Admin. Staff Transportation							3,419	3,419			25
26	Insurance-Prop.Liab.Malpractice			42,748	42,748		42,748	521	43,269			26
27	Other (specify):*											27
28	TOTAL General Administration	99,555	1,546	380,629	481,730		481,730	(75,258)	406,472			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,421,192	284,911	745,986	2,452,089		2,452,089	(68,360)	2,383,729			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			18,007	18,007		18,007	39,874	57,881			30
31	Amortization of Pre-Op. & Org.			7,599	7,599		7,599	60,789	68,388			31
32	Interest			62,003	62,003		62,003	227,688	289,691			32
33	Real Estate Taxes			24,963	24,963		24,963	188	25,151			33
34	Rent-Facility & Grounds			218,763	218,763		218,763	(218,763)				34
35	Rent-Equipment & Vehicles			15,971	15,971		15,971	1,733	17,704			35
36	Other (specify):*											36
37	TOTAL Ownership			347,306	347,306		347,306	111,509	458,815			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,930		12,930		12,930		12,930			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,563	136,563		136,563		136,563			42
43	Other (specify):*		8	25,999	26,007		26,007	(26,007)				43
44	TOTAL Special Cost Centers		12,938	162,562	175,500		175,500	(26,007)	149,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,421,192	297,849	1,255,854	2,974,895		2,974,895	17,142	2,992,037			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	(1,815)	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	(2,085)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(22,043)	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	(168)	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	(7,471)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,736)		\$	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)	50,878	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 50,878		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 17,142		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			Sch. V Line
	Amount	Reference	
1	Labs-Part A	\$ (2,035)	43
2	X-Rays-Part A	(1,409)	43
3	Offset of Transportation Income	(217)	11
4	Disallowed Special Events	(198)	43
5	Offset Office Supplies Miscellaneous Revenue	(13)	21
6	Offset Nursing Supplies Miscellaneous Revenue	(3,599)	11
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
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	(7,471)	

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%	\$ 4,773	\$ 4,773	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	92	92	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	326	326	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,866	2,866	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%	4,472	4,472	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	163,600	Petersen Health Care Management, Inc.	100.00%	26,542	(137,058)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	15,678	15,678	12
13	V								13
14	Total			\$ 163,600			\$ 54,749	\$ * (108,851)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,443	\$ 2,443	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	29,592	29,592	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	8,124	8,124	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	49	49	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	15	15	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,419	3,419	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	521	521	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,831	4,831	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	235	235	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	188	188	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,733	1,733	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			\$			\$ 51,150	\$ * 51,150	39

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

Facility Name & ID Number Eastview Terrace# 0056507Report Period Beginning: 1/1/2020Ending: 12/31/2020

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, Inc.	100.00%	\$	15
16	V	2 Food		Petersen Health Quality, Inc.	100.00%		16
17	V	3 Housekeeping		Petersen Health Quality, Inc.	100.00%		17
18	V	4 Laundry		Petersen Health Quality, Inc.	100.00%		18
19	V	5 Utilities		Petersen Health Quality, Inc.	100.00%		19
20	V	6 Maintenance		Petersen Health Quality, Inc.	100.00%		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Quality, Inc.	100.00%		21
22	V	10 Nursing and Medical Records		Petersen Health Quality, Inc.	100.00%		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Quality, Inc.	100.00%		23
24	V	17 Administrative		Petersen Health Quality, Inc.	100.00%		24
25	V	19 Professional Services		Petersen Health Quality, Inc.	100.00%	1,972	1,972 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Quality, Inc.	100.00%		26
27	V	21 Clerical and General Office		Petersen Health Quality, Inc.	100.00%		27
28	V	22 Employee Benefits & Payroll		Petersen Health Quality, Inc.	100.00%		28
29	V	23 Inservice Training & Education		Petersen Health Quality, Inc.	100.00%		29
30	V	24 Travel and Seminar		Petersen Health Quality, Inc.	100.00%		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Quality, Inc.	100.00%		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Quality, Inc.	100.00%		32
33	V	30 Depreciation		Petersen Health Quality, Inc.	100.00%	298	298 33
34	V	31 Amortization		Petersen Health Quality, Inc.	100.00%		34
35	V	32 Interest		Petersen Health Quality, Inc.	100.00%	242	242 35
36	V	33 Real Estate Taxes		Petersen Health Quality, Inc.	100.00%		36
37	V	34 Rent-Facility and Grounds		Petersen Health Quality, Inc.	100.00%		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Quality, Inc.	100.00%		38
39	Total		\$			\$ 2,512	\$ * 2,512 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 Maintenance	\$	Arcola Land Company, LLC	100.00%	\$	\$	15
16	V	19 Professional Services	\$	Arcola Land Company, LLC	100.00%			16
17	V	21 Equipment		Arcola Land Company, LLC	100.00%			17
18	V	26 Insurance-Property		Arcola Land Company, LLC	100.00%			18
19	V	26 Insurance-Mortgage Insurance		Arcola Land Company, LLC	100.00%			19
20	V	30 Depreciation		Arcola Land Company, LLC	100.00%	36,830	36,830	20
21	V	31 Amortization		Arcola Land Company, LLC	100.00%	60,789	60,789	21
22	V	32 Interest		Arcola Land Company, LLC	100.00%	227,211	227,211	22
23	V	33 Real Estate Taxes		Arcola Land Company, LLC	100.00%			23
24	V	34 Rent-Income and Grounds	218,763	Arcola Land Company, LLC	100.00%		(218,763)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 218,763			\$ 324,830	\$ * 106,067	39

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

Facility Name & ID Number

Eastview Terrace

0056507

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care, I	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enterp	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 LI	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	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 V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 Proper	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LLC	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

0056507

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

0056507

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Betty's Garden	Kewanee				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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	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# 0056507

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	17,924	\$ 4,773	1
2	2	Food	Resident Days	1,282,791	75	0	0	17,924	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	17,924	92	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	17,924	326	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	17,924	2,866	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,924	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	17,924	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	17,924	4,472	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	17,924	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	17,924	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	17,924	26,542	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	17,924	15,678	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	17,924	2,443	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	17,924	29,592	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,282,791	75	581,393	0	17,924	8,124	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	17,924	49	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	17,924	15	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	17,924	3,419	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	17,924	521	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	17,924	4,831	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	17,924	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	17,924	235	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	17,924	188	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	17,924	1,733	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 105,899	25

Facility Name & ID Number Eastview Terrace# 0056507 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	47,439	5	\$	\$	10,727	\$	1
2	2	Food	Resident Days	47,439	5			10,727		2
3	3	Housekeeping	Resident Days	47,439	5			10,727		3
4	4	Laundry	Resident Days	47,439	5			10,727		4
5	5	Utilities	Resident Days	47,439	5			10,727		5
6	6	Maintenance	Resident Days	47,439	5			10,727		6
7	7	Mgmt. Allocation of Benefits	Resident Days	47,439	5			10,727		7
8	10	Nursing and Medical Records	Resident Days	47,439	5			10,727		8
9	15	Mgmt. Allocation of Benefits	Resident Days	47,439	5			10,727		9
10	17	Administrative	Resident Days	47,439	5			10,727		10
11	19	Professional Services	Resident Days	47,439	5	8,721		10,727	1,972	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	47,439	5			10,727		12
13	21	Clerical and General Office	Resident Days	47,439	5			10,727		13
14	22	Employee Benefits & Payroll	Resident Days	47,439	5			10,727		14
15	23	Inservice Training & Education	Resident Days	47,439	5			10,727		15
16	24	Travel and Seminar	Resident Days	47,439	5			10,727		16
17	25	Other Admin. Staff Transport.	Resident Days	47,439	5			10,727		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	47,439	5			10,727		18
19	30	Depreciation	Resident Days	47,439	5	1,320		10,727	298	19
20	31	Amortization	Resident Days	47,439	5			10,727		20
21	32	Interest	Resident Days	47,439	5	1,070		10,727	242	21
22	33	Real Estate Taxes	Resident Days	47,439	5			10,727		22
23	34	Rent-Facility and Grounds	Resident Days	47,439	5			10,727		23
24	35	Rent-Equipment & Vehicles	Resident Days	47,439	5			10,727		24
25	TOTALS					\$ 11,111	\$		\$ 2,512	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	\$ Paid	7/31/2020	Varies	\$ 62,003	1
2	Sector		X	Mortgage	Varies	4/1/2020	3,642,037	3,642,037	3/31/23	Varies	227,211	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 5,124,718	\$ 3,642,037			\$ 289,214	9
	B. Non-Facility Related*											
10												10
11								Home Office Allocation-PHCM			235	11
12								Home Office Allocation-PHQ			242	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 477	14
15	TOTALS (line 9+line14)						\$ 5,124,718	\$ 3,642,037			\$ 289,691	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.

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 08-08-01-202-037	Long-Term Care Facility	\$ 24,207.86	\$ 24,207.86
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 24,207.86	\$ 24,207.86

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082

B. General Construction Type: Exterior BrickFrame 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: 182,368

2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 68,388

4. Dates Incurred: 2020

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	\$ 528,023	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete Pad		2000		500		20	25	25	448	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	38,433	12
13	Remodeling		2001		6,245		39	160	160	3,337	13
14	Medicare wing upgrade		2002		88,301		39	2,283	2,283	44,885	14
15	Roofing		2002		14,200		39	364	364	7,117	15
16	Window Balance		2004		1,714		7			1,714	16
17	Grease interceptor		2005		15,589		20	779	779	11,852	17
18	Sidewalks		2005		4,919		20	246	246	3,717	18
19	Pipe Work		2006		3,700		25	148	148	2,146	19
20	Sidewalks		2007		4,420		15	295	295	3,982	20
21	Replace Exterior Storage Shed (Including Demolition of Old)		2008		5,000		20	250	250	3,125	21
22	Wall Flashing-Dining Room		2011		4,700		15	314	314	2,983	22
23	Sprinkler System Replacement		2011		45,990		15	3,066	3,066	22,995	23
24	Parking Lot Grading		2013		3,250		7	234	234	3,250	24
25	Vinyl Flooring-Hallways, Common Area, and Offices		2013		29,569		25	1,182	1,182	8,865	25
26	Wandering Alert System		2014		4,295		7	614	614	3,991	26
27	Block Wall Repair		2014		3,800		7	543	543	3,530	27
28	Parking Lot Repaving		2014		44,457		15	2,963	2,963	19,260	28
29	Roof Replacement-North and West Section		2014		39,850		25	1,594	1,594	10,361	29
30	Irrigation Installation		2014		4,790		15	319	319	2,074	30
31	Cabinet and Countertop Replacement		2014		2,865		15	191	191	1,242	31
32	Window Replacement-North and West Section		2014		18,199		15	1,213	1,213	7,885	32
33	Repairs and Downspout Replacement-South Section		2014		16,192		15	1,079	1,079	7,014	33
34	Air Conditioner and Furnace-Rooftop		2017		5,788		15	386	386	1,351	34
35	Door Alarm System Replacement		2018		3,891		7	278	278	834	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 Door Alarm System Installation	2020	\$ 3,918	\$	7	\$ 280	\$ 280	\$ 280	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 Land Improvements Booked			671			(671)		57
58 Building Booked			25,194			(25,194)		58
59 Building Improvement Booked			21,317			(21,317)		59
60								60
61 2020-Home Office Allocation-Building Improvements		9,063			217	217		61
62 2020-Home Office Allocation-Land Improvements		909			58	58		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,445,400	\$ 47,182		\$ 46,128	\$ (1,054)	\$ 749,150	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	\$64,877	\$7,306	\$6,637	\$(669)	5-10 yrs.	\$43,103	71
72	Current Year Purchases	3,668	349	262	(87)	7 yrs.	262	72
73	Fully Depreciated Assets	302,913					302,913	73
74	Home Office Allocation			4,854	4,854			74
75	TOTALS	\$371,458	\$7,655	\$11,753	\$4,098		\$346,278	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)	\$1,945,186	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,837	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$57,881	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,044	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,123,756	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			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?

☐ YES

☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:

☐ YES

☐ NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

☒ YES

☐ NO
16. Rental Amount for movable equipment: \$17,704Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Eastview Terrace
0056507
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

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

Medical Equipment	\$	11,965
Dishwasher		701
Copier		3,305
Home Office Allocation		<u>1,733</u>
		<u><u>17,704</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.)										
		1	2	3	4	5	6	7	8	
	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	\$	6,000	\$ 89,999	\$	6,000	\$ 89,999	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,048	30,725		2,048	30,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,875	73,124		4,875	73,124	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				12,930		12,930	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			\$	12,923	\$ 193,848	\$ 12,930	12,923	\$ 206,778	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	\$ (26,898)	\$ (26,898)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 126,186)	1,181,451	1,181,451	3
4	Supply Inventory (priced at Cost)	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,260	19,260	6
7	Other Prepaid Expenses	56,500	56,500	7
8	Accounts Receivable (owners or related parties)		7,057	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,242,606	\$ 1,249,663	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		991,628	14
15	Leasehold Improvements, at Historical Cost		453,772	15
16	Equipment, at Historical Cost	28,328	399,786	16
17	Accumulated Depreciation (book methods)	(28,328)	(1,123,756)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,980	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	27,828	306,939	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	317,771	348,890	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 345,599	\$ 1,591,239	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,588,205	\$ 2,840,902	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 462,586	\$ 462,586	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,713	60,713	30
31	Accrued Taxes Payable (excluding real estate taxes)	83,560	83,560	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,191	24,191	32
33	Accrued Interest Payable		49,010	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	76,677	76,677	36
37	Accrued Management Fees	7,057	7,057	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 714,784	\$ 763,794	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,642,037	40
41	Bonds Payable			41
42	Deferred Compensation	20,951	20,951	42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	523,000	523,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 543,951	\$ 4,185,988	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,258,735	\$ 4,949,782	46
47	TOTAL EQUITY (page 18, line 24)	\$ 329,470	\$ (2,108,880)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,588,205	\$ 2,840,902	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (694,618)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	427,341	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (267,277)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	596,747	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)	\$ 596,747	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)	\$ 329,470	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastview Terrace

0056507

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	\$ 3,526,114	1
2	Discounts and Allowances for all Levels	(644,251)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,881,863	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	352,554	6
7	Oxygen	(14)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 352,540	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,815	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,001	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,052	20
21	Other Medical Services	4,125	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 31,993	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	217	28
28a	Miscellaneous and COVID Stimulus Revenue	305,029	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 305,246	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,571,642	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	622,626	31
32	Health Care	1,347,733	32
33	General Administration	481,730	33
	B. Capital Expense		
34	Ownership	347,306	34
	C. Ancillary Expense		
35	Special Cost Centers	38,937	35
36	Provider Participation Fee	136,563	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,974,895	40
41	Income before Income Taxes (line 30 minus line 40)**	596,747	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 596,747	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,967,259	44
45	Private Pay - Net Inpatient Revenue	551,610	45
46	Medicare - Net Inpatient Revenue	343,030	46
47	Other-(specify) Insurance Net Inpatient Revenue	19,964	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,881,863	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.

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	2,080	2,080	\$ 72,583	\$ 34.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,307	5,553	154,938	27.90	3
4	Licensed Practical Nurses	9,234	9,563	228,168	23.86	4
5	CNAs & Orderlies	33,032	34,170	467,078	13.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,699	1,779	26,272	14.77	9
10	Activity Assistants					10
11	Social Service Workers	2,183	2,203	32,877	14.92	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	40,100	19.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,506	10,016	108,219	10.80	15
16	Dishwashers					16
17	Maintenance Workers	1,825	1,849	37,411	20.23	17
18	Housekeepers	8,801	9,055	105,944	11.70	18
19	Laundry					19
20	Administrator	2,080	2,080	67,500	32.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,030	2,080	32,055	15.41	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	220	220	5,248	23.85	31
32	Other Health Care(specify)					32
33	Other(specify) CPC	1,487	1,605	42,799	26.67	33
34	TOTAL (lines 1 - 33)	81,564	84,333	\$ 1,421,192 *	\$ 16.85	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	8	\$ 406	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	5,598	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	7,920	L10, C3	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)	8	\$ 25,924		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	22	\$ 719	L10,C3	50
51	Licensed Practical Nurses	458	12,378	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	480	\$ 13,097		53

Eastview Terrace
0056507
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,012

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	276
Duane Morris	Legal	386
Lexis Nexis	Legal	8
Livingston, Barger, Brant, Schroeder	Legal	15
Miller, Hall, Triggs	Legal	48
Miscellaneous	Legal	18
SB2	Legal	143
SmithAmundsen LLC	Legal	882
Sorling Northrup	Legal	252
Thompson Burton	Legal	136
CliftonLarsonAllen	Accounting	2,218
Ginoli & Co.	Accounting	1,497
Ability Network	Computer Services	2,814
Allscripts	Computer Services	444
AOD Matrix Care	Computer Services	4,941
AT&T	Computer Services	5
ATS	Computer Services	269
CCH	Computer Services	16
Charter Communications	Computer Services	25
Citrix Systems	Computer Services	84
Comcast	Computer Services	29
ITSavvy	Computer Services	130
Kemper Technology	Computer Services	642
Miscellaneous	Computer Services	125
Pearl Technology	Computer Services	116
Stratus Networks	Computer Services	510
TR Professional	Computer Services	11
David Budde	Other Prof Fees	11
DJ Howard and Associates	Other Prof Fees	21
Getzler Henrich & Associates	Other Prof Fees	87
LRI Consulting Services	Other Prof Fees	85
McQuellon Consulting	Other Prof Fees	53
Miscellaneous	Other Prof Fees	98
Optimizer	Other Prof Fees	46
Registered Agent Solutions	Other Prof Fees	25
RSM McGladrey	Other Prof Fees	279
SB2	Other Prof Fees	357
Sedgwick CMS	Other Prof Fees	481
Tarver Program Consultants	Other Prof Fees	67

Total (agree to Schedule V, line 19, column 8)	<u>28,662</u>
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Eastview Terrace
0056507
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	-
Auto Repairs		-
Mileage-Travel		-
Home Office Allocation		3,419
		<u>3,419</u>
		<u>3,419</u>

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

No

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 20,418 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 136,563

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 1,815

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes \$ 217

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(18)

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

Yes

(19)

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

No