

		FOR OHF USE				

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**2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)**

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.

<p>I. IDPH Facility ID Number: <u>0044578</u></p> <p>Facility Name: <u>Eastview Terrace</u></p> <p>Address: <u>Eastview Place</u> <u>Sullivan</u> <u>61951</u> Number City Zip Code</p> <p>County: <u>Moultrie</u></p> <p>Telephone Number: <u>(217) 728-7367</u> Fax # <u>(217) 728-8405</u></p> <p>IDPA ID Number: <u>371346306003</u></p> <p>Date of Initial License for Current Owners: <u>02/01/00</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 12/01/02

	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	0	Skilled (SNF)	63		1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	0	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	3 Private Pay	4 Other		
8	SNF			17	17	8
9	SNF/PED					9
10	ICF	16,254	4,049		20,303	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,254	4,049	17	20,320	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.37%

D. How many bed-hold days during this year were paid by Public Aid? 0 (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)

Yes - 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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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 01/01/2000

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

YES Date 02/01/2000 NO

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

YES NO If YES, enter number of beds certified 8 and days of care provided 17

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number Eastview Terrace # 0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	135,988	13,339	200	149,527		149,527		149,527		1
2	Food Purchase		88,695		88,695		88,695	(22,095)	66,600		2
3	Housekeeping	58,399	15,731		74,130		74,130		74,130		3
4	Laundry	29,337	10,346		39,683		39,683		39,683		4
5	Heat and Other Utilities			55,510	55,510		55,510	342	55,852		5
6	Maintenance	27,330	25,904	7,126	60,360		60,360	1,882	62,242		6
7	Other (specify):*										7
8	TOTAL General Services	251,054	154,015	62,836	467,905		467,905	(19,871)	448,034		8
B. Health Care and Programs											
9	Medical Director			11,100	11,100		11,100		11,100		9
10	Nursing and Medical Records	585,686	45,977	1,031	632,694		632,694		632,694		10
10a	Therapy		131	12,658	12,789		12,789		12,789		10a
11	Activities	15,473	371	495	16,339		16,339		16,339		11
12	Social Services		36	495	531		531		531		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	601,159	46,515	25,779	673,453		673,453		673,453		16
C. General Administration											
17	Administrative	115,902		17,666	133,568		133,568	(17,666)	115,902		17
18	Directors Fees										18
19	Professional Services			20,961	20,961		20,961	7,481	28,442		19
20	Dues, Fees, Subscriptions & Promotions			8,684	8,684		8,684	(1,098)	7,586		20
21	Clerical & General Office Expenses	39,368	4,510	12,390	56,268		56,268	9,908	66,176		21
22	Employee Benefits & Payroll Taxes			200,778	200,778		200,778	11,713	212,491		22
23	Inservice Training & Education			2,411	2,411		2,411	380	2,791		23
24	Travel and Seminar			2,020	2,020		2,020	958	2,978		24
25	Other Admin. Staff Transportation			2,489	2,489		2,489	899	3,388		25
26	Insurance-Prop.Liab.Malpractice			31,050	31,050		31,050	1,378	32,428		26
27	Other (specify):*										27
28	TOTAL General Administration	155,270	4,510	298,449	458,229		458,229	13,953	472,182		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,007,483	205,040	387,064	1,599,587		1,599,587	(5,918)	1,593,669		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Eastview Terrace

#0044578

Report Period Beginning:

01/01/02

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			94,854	94,854		94,854	(11,294)	83,560			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,427	102,427		102,427	386	102,813			32
33	Real Estate Taxes			12,356	12,356		12,356	(2,111)	10,245			33
34	Rent-Facility & Grounds							2,046	2,046			34
35	Rent-Equipment & Vehicles			1,158	1,158		1,158	311	1,469			35
36	Other (specify):*											36
37	TOTAL Ownership			210,795	210,795		210,795	(10,662)	200,133			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Nonallowable Costs			43,706	43,706		43,706	(43,706)				43
44	TOTAL Special Cost Centers			78,199	78,199		78,199	(43,706)	34,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,007,483	205,040	676,058	1,888,581		1,888,581	(60,286)	1,828,295			45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning: 01/01/02

Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,937)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,550)	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	(172)	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				18
19	Entertainment				19
20	Contributions	(225)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,791)	43		24
25	Fund Raising, Advertising and Promotional	(6,884)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(57,430)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (89,989)		\$	30

OHF 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	2	
		Amount	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)	29,703		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 29,703		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (60,286)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace

ID# 0044578

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Amortization of goodwill	\$ (24,672)	43	1
2	Special events	(2,167)	43	2
3	Resident promotions	(858)	43	3
4	Meal income offset	(1,922)	2	4
5	Miscellaneous income offset	(360)	21	5
6	Non-allowable Chamber of Commerce dues	(1,555)	20	6
7	Deferred maintenance	1,273	6	7
8	Real estate taxes on Administrator's house	(2,111)	33	8
9	Offset Inmate Meal revenue against food cost	(20,173)	2	9
10	Amortization of loan costs	4,333	32	10
11	Non-allowable interest on house	(9,218)	32	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	(57,430)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(22,095)	0	0	0	0	0	0	0	0	0	0	(22,095)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	342	0	0	0	0	0	0	0	0	0	342	5
6	Maintenance	1,273	609	0	0	0	0	0	0	0	0	0	1,882	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,822)	951	0	0	0	0	0	0	0	0	0	(19,871)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(17,666)	0	0	0	0	0	0	0	0	0	(17,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,481	0	0	0	0	0	0	0	0	0	7,481	19
20	Fees, Subscriptions & Promotions	(1,555)	457	0	0	0	0	0	0	0	0	0	(1,098)	20
21	Clerical & General Office Expenses	(360)	10,268	0	0	0	0	0	0	0	0	0	9,908	21
22	Employee Benefits & Payroll Taxes	0	11,713	0	0	0	0	0	0	0	0	0	11,713	22
23	Inservice Training & Education	0	380	0	0	0	0	0	0	0	0	0	380	23
24	Travel and Seminar	0	958	0	0	0	0	0	0	0	0	0	958	24
25	Other Admin. Staff Transportation	0	899	0	0	0	0	0	0	0	0	0	899	25
26	Insurance-Prop.Liab.Malpractice	0	1,378	0	0	0	0	0	0	0	0	0	1,378	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,915)	15,868	0	0	0	0	0	0	0	0	0	13,953	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,737)	16,819	0	0	0	0	0	0	0	0	0	(5,918)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(16,550)	5,256	0	0	0	0	0	0	0	0	0	(11,294)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,885)	5,271	0	0	0	0	0	0	0	0	0	386	32
33	Real Estate Taxes	(2,111)	0	0	0	0	0	0	0	0	0	0	(2,111)	33
34	Rent-Facility & Grounds	0	0	2,046	0	0	0	0	0	0	0	0	2,046	34
35	Rent-Equipment & Vehicles	0	0	311	0	0	0	0	0	0	0	0	311	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,546)	10,527	2,357	0	0	0	0	0	0	0	0	(10,662)	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):*	(43,706)	0	0	0	0	0	0	0	0	0	0	(43,706)	43
44	TOTAL Special Cost Centers	(43,706)	0	0	0	0	0	0	0	0	0	0	(43,706)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(89,989)	27,346	2,357	0	0	0	0	0	0	0	0	(60,286)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	See	See Attached Schedule 6A		See Attached Schedule 6A		
Mark Petersen	Attached					
	Sch 6A					

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	Petersen Health Care Companies	0.00%	\$ 342	\$ 342	1
2	V	6 Maintenance		Petersen Health Care Companies	0.00%	609	609	2
3	V	17 Administrative	17,666	Petersen Health Care Companies	0.00%		(17,666)	3
4	V	19 Professional Services		Petersen Health Care Companies	0.00%	7,481	7,481	4
5	V	20 Dues, Fees, & Subscriptions		Petersen Health Care Companies	0.00%	457	457	5
6	V	21 Clerical & General Office		Petersen Health Care Companies	0.00%	10,268	10,268	6
7	V	22 Employee Benefits		Petersen Health Care Companies	0.00%	11,713	11,713	7
8	V	23 Inservice Training		Petersen Health Care Companies	0.00%	380	380	8
9	V	24 Travel & Seminar		Petersen Health Care Companies	0.00%	958	958	9
10	V	25 Other Admin Staff. Transport.		Petersen Health Care Companies	0.00%	899	899	10
11	V	26 Insurance		Petersen Health Care Companies	0.00%	1,378	1,378	11
12	V	30 Depreciation		Petersen Health Care Companies	0.00%	5,256	5,256	12
13	V	32 Interest		Petersen Health Care Companies	0.00%	5,271	5,271	13
14	Total		\$ 17,666			\$ 45,012	\$ * 27,346	14

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

Facility Name & ID Number Eastview Terrace # 0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	34 Rent - Facility & Grounds	\$	Petersen Health Care Companies	0.00%	\$ 2,046	\$	2,046	15
16	V	35 Rent - Equipment & Vehicles		Petersen Health Care Companies	0.00%	311		311	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								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		\$			\$ 2,357	\$ *	2,357	39

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

Eastview Terrace
Provider # 0044578
12/31/2002

Schedule 6A

VII Related Parties-Page 6

Related Nursing Homes

	<u>City</u>
Robings Manor Nursing Home	Brighton, IL
Bement Health Care Center	Bement, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie City Health Care Center *	Prairie City, IL

Out of State Nursing Homes

Meadow Lawn Nursing Center	Davenport, IA
Friendly Village *	Rhineland, WI
Horizons Unlimited *	Rhineland, WI
Taylor Park *	Rhineland, WI
Passport *	Rhineland, WI
Cumberland Heights-Tomahawk *	Tomahawk, WI
Maple Park *	Rhineland, WI
Opportunities Unlimited (Workshop setup, no beds)	

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor

Related Assisted Living Facilities

Courtyard Estates	Kewanee, IL
-------------------	-------------

* Not affiliated after 08/30/02.

Ownership Percentages:	<u>01/01/02 - 08/30/02</u>	<u>08/31/02 - 12/31/02</u>
James Petersen	60.00%	0.00%
Mark Petersen	40.00%	100.00%

Facility Name & ID Number Eastview Terrace # 0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	James Petersen	Ex-President	Administrative	See	305,329	1	2.50	Salary	\$ 29,671	17(1)	1
2	Mark Petersen	President	Administrative	Attached	113,929	1	2.50	Salary	11,071	17(1)	2
3	Mark Petersen	Administrative	Administrative	Schedule	114,840	1	2.50	Salary	11,160	17(1)	3
4	Todd Petersen	Administrative	Administrative	6A	62,015	1	2.50	Salary	6,027	21(1)	4
5											5
6											6
7											7
8			See Attached Schedule 7A								8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,929		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

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
 PROVIDER # 0044578
 12/31/2002

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 7A

VII. RELATED PARTIES (continued)

**C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board Of Directors.
 Compensation Received From Other Nursing Homes**

Name	ARCOLA HEALTH CARE	BEMENT HEALTH CARE	COUNTRYVIEW TERRACE	KEWANEE HEALTH CARE	MEADOW LAWN NURSING	ROBINGS MANOR	SUNSET MANOR	HAVANA CARE CENTER	PRAIRIE CITY	PALM TERRACE OF MATTOON	TOTAL COMPENSATION FROM OTHER NURSING HOMES	EASTVIEW TERRACE	TOTAL COMPENSATION
JAMES PETERSEN	50,451	29,605	8,487	39,308	33,470	34,462	54,493	40,847	8,796	5,410	305,329	29671	335,000
MARK PETERSEN	18,825	11,047	3,166	14,668	12,489	12,859	20,333	15,242	3,282	2,018	113,929	11071	125,000
MARK PETERSEN - Administrative	18,976	11,135	3,192	14,785	12,589	12,962	20,496	15,363	3,308	2,034	114,840	11160	126,000
TODD PETERSEN	10,247	6,013	1,724	7,984	6,798	7,000	11,068	8,297	1,787	1,097	62,015	6027	68,042
Total Compensation Received From Other Nursing Homes	98,499	57,800	16,569	76,745	65,346	67,283	106,390	79,749	17,173	10,559	596,113	57,929	654,042

Facility Name & ID Number Eastview Terrace # 0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care Companies
 Street Address 7218 North Villa Lake
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	\$ 3,858	20,320	\$ 342	1
2	6	Maintenance Supplies	Patient Days	229,422	11	6,877	20,320	609	2
3	19	Professional Services	Patient Days	229,422	11	84,471	20,320	7,481	3
4	20	Dues, Fee, & Subscriptions	Patient Days	229,422	11	5,163	20,320	457	4
5	21	Clerical & General Office	Patient Days	229,422	11	115,931	20,320	10,268	5
6	22	Employee Benefits	Patient Days	229,422	11	132,243	20,320	11,713	6
7	23	Inservice Training	Patient Days	229,422	11	4,287	20,320	380	7
8	24	Travel & Seminars	Patient Days	229,422	11	10,813	20,320	958	8
9	25	Other Admin. Staff Transport.	Patient Days	229,422	11	10,154	20,320	899	9
10	26	Insurance	Patient Days	229,422	11	15,558	20,320	1,378	10
11	30	Depreciation	Patient Days	229,422	11	59,343	20,320	5,256	11
12	32	Interest	Patient Days	229,422	11	59,511	20,320	5,271	12
13	34	Rent - Facility & Grounds	Patient Days	229,422	11	23,100	20,320	2,046	13
14	35	Rent - Equipment & Vehicles	Patient Days	229,422	11	3,511	20,320	311	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 534,820	\$	\$ 47,369	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0044578 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	First Bank		X	Mortgage	\$11,561.00	12/20/99	\$ 1,318,000	\$	02/12/03	0.0542	\$ 31,720	1
2	First Bank		X	Van purchase	\$868.00	02/12/00	52,075	22,566	02/12/05	0.0750	1,754	2
3	Bank of Farmington		X	Car purchase	\$499.00	03/28/01	11,967	1,498	04/27/03	0.0790	466	3
4	LaSalle Bank		X	Mortgage	2044 + interest	08/31/02	1,887,097	1,878,921	08/31/07	varies	51,276	4
5												5
	Working Capital											
6	First Bank		X	Working capital	Interest only	12/20/99	150,000		12/01/02	0.0575	4,720	6
7	LaSalle Bank		X	Working capital	Interest only	08/31/02	163,723	163,723	08/31/03	varies	3,273	7
8												8
9	TOTAL Facility Related				\$12,928.00		\$ 3,582,862	\$ 2,066,708			\$ 93,209	9
	B. Non-Facility Related*											
10	Amortization of loan costs											
11	Allocated from Mgnt. Co.											
12	People's National Bank		X	Purchase house	Various	03/01/01	135,671		03/01/16	prime	9,218	12
13	Less: Non-allowable interest on house											
14	TOTAL Non-Facility Related						\$ 135,671	\$			\$ 9,604	14
15	TOTALS (line 9+line14)						\$ 3,718,533	\$ 2,066,708			\$ 102,813	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0044578

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 08-008-01-202-037	Facility & Grounds	\$ 10,417.00	\$ 10,417.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>10,417.00</u>	\$ <u>10,417.00</u>

B. Real Estate Tax Cost Allocation:

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Eastview Terrace

0044578 Report Period Beginning:

01/01/02 Ending:

12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082 B. General Construction Type: Exterior Block Frame Steel Number of Stories OneC. 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 ground:
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)NoneF. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/ANature of Costs: N/A

(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	Resident care	217,546	2000	\$ 100,000	1
2					2
3	TOTALS	217,546		\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	2000	1976	\$ 982,565	\$ 25,194	39	\$ 25,194		\$ 75,582	4
5	6	2000	1985							5
6										6
7										7
8										8
Improvement Type**										
9	Water Heater	2000		4,800	840	7	686	(154)	1,715	9
10	Concrete Pad	2000		500	13	20	25	12	63	10
11	Painting Exterior Building	2000		2,480	476	5	496	20	1,240	11
12	Fence	2000		3,952	338	15	264	(74)	660	12
13	Asphalt Parking Lot	2000		2,370	203	15	158	(45)	395	13
14	Carpet	2000		503	88	7	72	(16)	180	14
15	Flooring	2001		72,265	1,853	39	1,853		2,779	15
16	Remodeling	2001		6,245	160	39	160		240	16
17	Roofing	2001		2,159	55	39	55		83	17
18	Roofing	2001		12,000	308	39	308		462	18
19	Replacement - Glass	2001		1,179	202	7	168	(34)	252	19
20	Medicare wing upgrade	2002		89,018	1,301	39	1,301		1,301	20
21	Roofing	2002		14,200	197	39	197		197	21
22	Flooring	2002		4,263	50	39	50		50	22
23	Architects Fee	2002		1,916	6	39	6		6	23
24	Wall hangings	2002		3,220	1,288	7	230	(1,058)	230	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$	\$	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										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)			\$ 1,203,635	\$ 32,572		\$ 31,223	\$ (1,349)	\$ 85,435	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 242,636	\$ 46,663	\$ 35,381	\$ (11,282)	5-7	\$ 94,051	71
72	Current Year Purchases	14,397	3,959	1,028	(2,931)	7	1,028	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co			5,256	5,256			74
75	TOTALS	\$ 257,033	\$ 50,622	\$ 41,665	\$ (8,957)		\$ 95,079	75

D. Vehicle Depreciation (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	Plymouth Voyager 2000	2000	\$ 42,307	\$ 8,123	\$ 8,461	\$ 338		\$ 25,383	76
77	Resident care	Malibu 2000	2001	11,054	3,537	2,211	(1,326)		3,316	77
78										78
79										79
80	TOTALS			\$ 53,361	\$ 11,660	\$ 10,672	\$ (988)		\$ 28,699	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)	\$ 1,614,029	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,854	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,560	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,294)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 209,213	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	7
3	Original Building:			\$			3
4	Additions						4
5		<u>Allocated from Management Company</u>		<u>2,046</u>			5
6							6
7	TOTAL			\$ <u>2,046</u>			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 N/A None
N/A

9. Option to Buy: YES NO Terms: N/A*

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: \$ 1,469 Description: Oxygen concentrators - 1,158; Allocated from Management Co. - 311
 (Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	7
17			\$	\$	17
18					18
19			<u>N/A</u>		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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF AIDES 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 aides 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 aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	185	\$ 2,782					185	\$ 2,782	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		79	1,178					79	1,178	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10A(2), (3)	hrs		580	8,698			131		580	8,829	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts										9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$	844	\$ 12,658			\$ 131		844	\$ 12,789	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
Provider #: 0044578
01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
	L39, C3			
Total			<u>0</u>	<u>0</u>

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	470,618	470,618	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,916	44,916	6
7	Other Prepaid Expenses	9,019	9,019	7
8	Accounts Receivable (owners or related parties)	687,672	687,672	8
9	Other(specify): <u>Employee advances</u>	600	600	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,213,325	\$ 1,213,325	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	1,203,635	1,203,635	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	310,394	310,394	16
17	Accumulated Depreciation (book methods)	(256,734)	(209,213)	17
18	Deferred Charges		637	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Loan cost, net</u>)		4,333	22
23	Other(specify): <u>Goodwill, net of amortization</u>	295,997	295,997	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,653,292	\$ 1,705,783	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,866,617	\$ 2,919,108	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 286,065	\$ 286,065	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	163,723	163,723	29
30	Accrued Salaries Payable	39,726	39,726	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,417	10,417	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued insurance</u>	33,246	33,246	36
37	<u>Accrued expenses</u>	4,381	4,381	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 537,558	\$ 537,558	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,064	24,064	39
40	Mortgage Payable	1,878,921	1,878,921	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,902,985	\$ 1,902,985	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,440,543	\$ 2,440,543	46
47	TOTAL EQUITY(page 18, line 24)	\$ 426,074	\$ 478,565	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,866,617	\$ 2,919,108	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 312,235	1
2	Restatements (describe):		2
3			3
4	Prior period adjustments	(7,190)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 305,045	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	171,029	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	(50,000)	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)	\$ 121,029	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)	\$ 426,074	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,008,444	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,008,444	3
B. Ancillary Revenue			
4	Day Care	375	4
5	Other Care for Outpatients		5
6	Therapy	14,172	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 14,547	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	35,544	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,544	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 income	715	28
28a	Miscellaneous income	360	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,075	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,059,610	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	467,905	31
32	Health Care	673,453	32
33	General Administration	458,229	33
B. Capital Expense			
34	Ownership	210,795	34
C. Ancillary Expense			
35	Special Cost Centers	43,706	35
36	Provider Participation Fee	34,493	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,888,581	40
41	Income before Income Taxes (line 30 minus line 40)**	171,029	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 171,029	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Entity files as a cash basis tax payer.

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

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

Facility Name & ID Number Eastview Terrace

0044578

Report Period Beginning: 01/01/02

Ending:

12/31/02

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	2,167	2,167	\$ 41,353	\$ 19.08	1
2	Assistant Director of Nursing	1,127	1,127	12,877	11.43	2
3	Registered Nurses	4,934	5,046	82,244	16.30	3
4	Licensed Practical Nurses	10,645	10,960	146,781	13.39	4
5	Nurse Aides & Orderlies	30,560	31,181	286,412	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,993	1,993	15,473	7.76	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,167	2,167	27,200	12.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,763	14,140	108,788	7.69	15
16	Dishwashers					16
17	Maintenance Workers	2,552	2,552	27,330	10.71	17
18	Housekeepers	8,657	8,702	58,399	6.71	18
19	Laundry	4,087	4,222	29,337	6.95	19
20	Administrator	2,167	2,167	64,000	29.53	20
21	Assistant Administrator					21
22	Other Administrative	498	498	51,902	104.22	22
23	Office Manager					23
24	Clerical	2,922	2,926	39,368	13.45	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	96	183	1,467	8.02	31
32	Other Health Care See Sch 20A	619	619	14,552	23.51	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,954	90,650	\$ 1,007,483 *	\$ 11.11	34

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	5	\$ 200	1(3)	35
36	Medical Director	Monthly	11,100	9(3)	36
37	Medical Records Consultant	Monthly	531	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	500	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	495	11(3)	44
45	Social Service Consultant	18	495	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	41	\$ 13,321		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Eastview Terrace
Provider #: 0044578
01/01/02 to 12/31/02

Schedule 20A

Line 32 - Other Health Care:

<u>Description</u>	Hours <u>Worked</u>	Hours <u>Paid</u>	Salary & <u>Wages</u>	Ave. Hrly. <u>Wage</u>
Care Plan Coordinator	97	97	4,089	42.15
Corporate Nurse	522	522	10,463	20.04
	<u>619</u>	<u>619</u>	<u>14,552</u>	<u>23.51</u>

See Accountants' Compilation Report

Eastview Terrace
Provider #: 0044578
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 20,961

Allocated from Management Company

See attached

Legal

729

Other

6,752

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

28,442

See Accountants' Compilation Report

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Carpet & chair cleaning	1/15/00	\$ 1,455	3	\$	\$ 243	\$ 485	\$ 485	\$ 242	\$	\$	\$
2	Hot water heater repair	4/12/00	2,366	3		395	788	788	395			
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 3,821		\$	\$ 638	\$ 1,273	\$ 1,273	\$ 637	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - 2,022
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,980 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,493
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 22,095
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 715
c. What percent of all travel expense relates to transportation of nurses and patients? 10%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet complete.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

Eastview Terrace

02:40 PM 11/04/05

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	-60,286	equal to	-60,286	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7	
Interest Expense	102,813	equal to	102,813	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8	
Real Estate Tax Expenses	10,245	equal to	10,245	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8	
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8	
Ownership Costs-Depreciation	83,560	equal to	83,560	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8	
Rental Costs A	2,046	equal to	2,046	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8	
Rental Costs B	1,469	equal to	1,469	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	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1	
Therapy Services	12,789	equal to	12,789	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4	
Special Serv.- Supplies	131	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2	
Income Stat. General Serv.	467,905	equal to	467,905	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4	
Income Stat. Health Care	673,453	equal to	673,453	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4	
Income Stat. Administration	458,229	equal to	458,229	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4	
Income Stat. Ownership	210,795	equal to	210,795	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4	
Income Stat. Special Cost Ctr	43,706	equal to	43,706	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38b41+43	4	
Income Stat. Prov. Partic.	34,493	equal to	34,493	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4	
Staff- Nursing	571,134	equal to	585,686	-14,552	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1	OK - On Line 32
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1	
Staff-License Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1	
Staff- Activities	15,473	equal to	15,473	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1	
Staff- Social Serv. Workers	0	equal to	0	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1	
Staff- Dietary	135,988	equal to	135,988	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1	
Staff- Maintenance	27,330	equal to	27,330	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1	
Staff- Housekeeping	58,399	equal to	58,399	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1	
Staff- Laundry	29,337	equal to	29,337	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1	
Staff- Administrative	115,902	equal to	115,902	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1	
Staff- Clerical	39,368	equal to	39,368	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1	
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1	
Total Salaries And Wages	1,007,483	equal to	1,007,483	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1	
Dietary Consultant	200	< or = to	200	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3	
Medical Director	11,100	< or = to	11,100	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3	
Consultants & contractors	1,031	< or = to	1,031	0	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3	
Activity Consultant	495	< or = to	495	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3	
Social Service Consultant	495	< or = to	495	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3	
Supp. Sched.- Admin. Salar.	115,902	equal to	115,902	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1	
Supp. Sched.- Admin. Other	17,666	equal to	17,666	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3	OK - Formula looking @ 17(3) instead of 17(8)
Supp. Sched.- Prof. Serv.	20,961	equal to	20,961	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3	
Supp. Sched.- Benefit/Taxes	212,491	equal to	212,491	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8	
Supp. Sched.- Sched of dues..	7,586	equal to	7,586	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8	
Supp. Sched.- Sched. of trav	2,978	equal to	2,978	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8	
Gen. Info - Particip. Fees	34,493	equal to	34,493	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3	
Gen. Info - Employee Meals	N/A	< or = to	11,713	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7	
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A	
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1	
Days of medicare provided	17	equal to	17	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4	
Adjustment for related org. costs	29,703	equal to	29,703	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4†	B.	14	8	
Total loan balance	2,066,708	equal to	2,066,708	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2	
Real estate tax accrual	10,417	equal to	10,417	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	1,203,635	equal to	1,203,635	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2	
Equipment and vehicle cost	310,394	equal to	310,394	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2	
Accumulated depr.	209,213	equal to	209,213	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2	
End of year equity	426,074	equal to	426,074	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1	
Net income (loss)	171,029	equal to	171,029	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2	
Unamortized deferred maint. cost	637	equal to	637	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2	
Balance Sheet	2,866,617	equal to	2,866,617	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1	

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	135,988	13,339	200	149,527	0	149,527	0	149,527
2. Food P	0	88,695	0	88,695	0	88,695	-22,095	66,600
3. Housek	58,399	15,731	0	74,130	0	74,130	0	74,130
4. Laundry	29,337	10,346	0	39,683	0	39,683	0	39,683
5. Heat ar	0	0	55,510	55,510	0	55,510	342	55,852
6. Mainte	27,330	25,904	7,126	60,360	0	60,360	1,882	62,242
7. Other (	0	0	0	0	0	0	0	0
8. Total G	251,054	154,015	62,836	467,905	0	467,905	-19,871	448,034
9. Medical	0	0	11,100	11,100	0	11,100	0	11,100
10. Nursin	585,686	45,977	1,031	632,694	0	632,694	0	632,694
10a. Ther	0	131	12,658	12,789	0	12,789	0	12,789
11. Activit	15,473	371	495	16,339	0	16,339	0	16,339
12. Social	0	36	495	531	0	531	0	531
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	601,159	46,515	25,779	673,453	0	673,453	0	673,453
17. Admin	115,902	0	17,666	133,568	0	133,568	-17,666	115,902
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	20,961	20,961	0	20,961	7,481	28,442
20. Fees,	0	0	8,684	8,684	0	8,684	-1,098	7,586
21. Cleric	39,368	4,510	12,390	56,268	0	56,268	9,908	66,176
22. Emplo	0	0	200,778	200,778	0	200,778	11,713	212,491
23. Inserv	0	0	2,411	2,411	0	2,411	380	2,791
24. Travel	0	0	2,020	2,020	0	2,020	958	2,978
25. Other	0	0	2,489	2,489	0	2,489	899	3,388
26. Insura	0	0	31,050	31,050	0	31,050	1,378	32,428
27. Other	0	0	0	0	0	0	0	0
28. Total I	155,270	4,510	298,449	458,229	0	458,229	13,953	472,182
29. Total J	1,007,483	205,040	387,064	1,599,587	0	1,599,587	-5,918	1,593,669
30. Depre	0	0	94,854	94,854	0	94,854	-11,294	83,560
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	102,427	102,427	0	102,427	386	102,813
33. Real E	0	0	12,356	12,356	0	12,356	-2,111	10,245
34. Rent -	0	0	0	0	0	0	2,046	2,046
35. Rent -	0	0	1,158	1,158	0	1,158	311	1,469
36. Other	0	0	0	0	0	0	0	0
37. Total K	0	0	210,795	210,795	0	210,795	-10,662	200,133
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	0	0	0	0	0	0	0
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	34,493	34,493	0	34,493	0	34,493
43. Other	0	0	43,706	43,706	0	43,706	-43,706	0
44. Total L	0	0	78,199	78,199	0	78,199	-43,706	34,493
45. Grand	1,007,483	205,040	676,058	1,888,581	0	1,888,581	-60,286	1,828,295

	After	Consolidation
General Service Cost Center		
1. Cash on	500	500
2. Cash - F	0	0
3. Account	470,618	470,618
4. Supply I	0	0
5. Short-Ter	0	0
6. Prepaid	44,916	44,916
7. Other Pr	9,019	9,019
8. Account	687,672	687,672
9. Other (s	600	600
10. Total c	1,213,325	1,213,325
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	100,000	100,000
14. Buildin	1,203,635	1,203,635
15. Lease	0	0
16. Equipn	310,394	310,394
17. Accum	-256,734	-209,213
18. Deferr	0	637
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	4,333
23. other (	295,997	295,997
24. Total L	1,653,292	1,705,783
25. Total A	2,866,617	2,919,108
CURRENT LIABILITIES		
26. Accour	286,065	286,065
27. Officer	0	0
28. Accour	0	0
29. Short-T	163,723	163,723
30. Accrue	39,726	39,726
31. Accrue	0	0
32. Accrue	10,417	10,417
33. Accrue	0	0
34. Deferr	0	0
35. Federa	0	0
36. Other (	37,627	37,627
37. Other (	0	0
38. Total C	537,558	537,558
LONG TERM LIABILITES		
39. Long-Tr	24,064	24,064
40. Mortga	1,878,921	1,878,921
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	1,902,985	1,902,985
46. Total Li	2,440,543	2,440,543
47. Total Ei	426,074	478,565
48. Total Li	2,866,617	2,919,108

Balance per
Medicaid
Trial Balance

1. Gross F 2,008,444
2. Discour 0

Subtota 2,008,444

4. Day Ca 375
5. Other C 0
6. Therapy 14,172
7. Oxygen 0

Subtota 14,547

9. Paymer 0
10. Other 0
11. Nurse: 0
12. Gift an 0
13. Barber 0
14. Non-P 35,544
15. Telept 0
16. Rental 0
17. Sale o 0
18. Sale o 0
19. Labor: 0
20. Radiol 0
21. Other 0
22. Laund 0

Subtot 35,544

24. Contrl 0
25. Interes 0

Subtot-

27. Other 715
28. Other 360
Subtot 1,075

30. Total F 2,059,610
31. Gener 467,905
32. Health 673,453
33. Gener 458,229
34. Owner 210,795
35. Specie 43,706
35. Provid 34,493
37. Other 0
40. Total E 1,888,581
41. Incom 171,029
42. Incom 0
43. Net In 171,029