

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0046060

Facility Name: Eastview Terrace

Address: 100 Eastview Place Sullivan 61951
 Number City Zip Code

County: Moultrie

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

HFS ID Number: 371346306003

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

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** 312-634-4581
 Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Date) _____
Paid Preparer	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>
	(Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>
	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,015	3,543	1,409	20,967	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,015	3,543	1,409	20,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.18%

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

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 02/01/2000

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 1,409

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006
 * All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	149,241	13,669	1,260	164,170		164,170	1,491	165,661		1
2	Food Purchase		110,111		110,111		110,111	(46,950)	63,161		2
3	Housekeeping	52,424	18,112		70,536		70,536	66	70,602		3
4	Laundry	39,518	17,174		56,692		56,692		56,692		4
5	Heat and Other Utilities			61,902	61,902		61,902	277	62,179		5
6	Maintenance	23,605	22,002	2,325	47,932		47,932	3,792	51,724		6
7	Other (specify): Home Office Benefits							597	597		7
8	TOTAL General Services	264,788	181,068	65,487	511,343		511,343	(40,727)	470,616		8
	B. Health Care and Programs										
9	Medical Director			9,800	9,800		9,800		9,800		9
10	Nursing and Medical Records	658,058	93,832	975	752,865		752,865	3,848	756,713		10
10a	Therapy			62,413	62,413		62,413	495	62,908		10a
11	Activities	18,239	647	3,422	22,308		22,308		22,308		11
12	Social Services	27,348	22		27,370		27,370		27,370		12
13	CNA Training										13
14	Program Transportation			486	486		486		486		14
15	Other (specify): Home Office Benefits							1,666	1,666		15
16	TOTAL Health Care and Programs	703,645	94,501	77,096	875,242		875,242	6,009	881,251		16
	C. General Administration										
17	Administrative	51,879			51,879		51,879	14,695	66,574		17
18	Directors Fees										18
19	Professional Services			12,984	12,984		12,984	5,972	18,956		19
20	Dues, Fees, Subscriptions & Promotions			3,663	3,663		3,663	(146)	3,517		20
21	Clerical & General Office Expenses	23,242	4,313	11,982	39,537		39,537	21,508	61,045		21
22	Employee Benefits & Payroll Taxes			147,126	147,126		147,126	4,423	151,549		22
23	Inservice Training & Education			127	127		127	192	319		23
24	Travel and Seminar			75	75		75	5,736	5,811		24
25	Other Admin. Staff Transportation			13,801	13,801		13,801	1,526	15,327		25
26	Insurance-Prop.Liab.Malpractice			25,311	25,311		25,311	1,129	26,440		26
27	Other (specify): Home Office Benefits							4,186	4,186		27
28	TOTAL General Administration	75,121	4,313	215,069	294,503		294,503	59,221	353,724		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,043,554	279,882	357,652	1,681,088		1,681,088	24,503	1,705,591		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

#0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			60,063	60,063		60,063	29,610	89,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,477	143,477		143,477	(675)	142,802			32
33	Real Estate Taxes			12,825	12,825		12,825	685	13,510			33
34	Rent-Facility & Grounds							664	664			34
35	Rent-Equipment & Vehicles			8,314	8,314		8,314	348	8,662			35
36	Other (specify):*											36
37	TOTAL Ownership			224,679	224,679		224,679	30,632	255,311			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,592		23,592		23,592		23,592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,494	34,494		34,494		34,494			42
43	Other (specify):* Nonallowable Cost			50,060	50,060		50,060	(50,060)				43
44	TOTAL Special Cost Centers		23,592	84,554	108,146		108,146	(50,060)	58,086			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,043,554	303,474	666,885	2,013,913		2,013,913	5,075	2,018,988			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

0046060

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	(42,585)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,273)	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	23,769	30		9
10	Interest and Other Investment Income	(3,919)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(698)	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	(435)	43		18
19	Entertainment				19
20	Contributions	(25)	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	(30,359)	43		24
25	Fund Raising, Advertising and Promotional	(9,378)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(11,870)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,773)		\$	30

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)	82,848	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 82,848		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 5,075		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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace

ID# 0046060

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Labs - Part A	\$ (3,917)	43	1
2	X-rays - Part A	(2,906)	43	2
3	Offset Vending machine expense	(69)	43	3
4	Offset Chamber of Commerce Dues	(776)	43	4
5	Misc Income - Med Supp	(1,542)	10	5
6	Misc Income - Food	(15)	2	6
7	Misc Income - Office Supply	(2,180)	21	7
8	Offset Home Office Architect Fees	(465)	19	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	(11,870)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,491	0	0	0	0	0	0	0	0	0	1,491	1
2	Food Purchase	(42,600)	73	0	0	0	0	0	0	0	0	0	(42,527)	2
3	Housekeeping	0	66	0	0	0	0	0	0	0	0	0	66	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	276	0	0	0	0	0	0	0	0	0	276	5
6	Maintenance	0	3,792	0	0	0	0	0	0	0	0	0	3,792	6
7	Other (specify):*	0	598	0	0	0	0	0	0	0	0	0	598	7
8	TOTAL General Services	(42,600)	6,296	0	0	0	0	0	0	0	0	0	(36,304)	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	(1,542)	5,390	0	0	0	0	0	0	0	0	0	3,848	10
10a	Therapy	0	495	0	0	0	0	0	0	0	0	0	495	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,666	0	0	0	0	0	0	0	0	0	1,666	15
16	TOTAL Health Care and Programs	(1,542)	7,551	0	0	0	0	0	0	0	0	0	6,009	16
	C. General Administration													
17	Administrative	0	14,695	0	0	0	0	0	0	0	0	0	14,695	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(465)	6,435	0	0	0	0	0	0	0	0	0	5,970	19
20	Fees, Subscriptions & Promotions	0	633	0	0	0	0	0	0	0	0	0	633	20
21	Clerical & General Office Expenses	(2,180)	0	23,688	0	0	0	0	0	0	0	0	21,508	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	192	0	0	0	0	0	0	0	0	192	23
24	Travel and Seminar	0	0	5,736	0	0	0	0	0	0	0	0	5,736	24
25	Other Admin. Staff Transportation	0	0	1,526	0	0	0	0	0	0	0	0	1,526	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,129	0	0	0	0	0	0	0	0	1,129	26
27	Other (specify):*	0	0	4,186	0	0	0	0	0	0	0	0	4,186	27
28	TOTAL General Administration	(2,645)	21,763	36,457	0	55,575	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,787)	35,610	36,457	0	25,280	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	23,769	0	5,840	0	0	0	0	0	0	0	0	29,609	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,919)	0	3,244	0	0	0	0	0	0	0	0	(675)	32
33	Real Estate Taxes	0	0	685	0	0	0	0	0	0	0	0	685	33
34	Rent-Facility & Grounds	0	0	664	0	0	0	0	0	0	0	0	664	34
35	Rent-Equipment & Vehicles	0	0	348	0	0	0	0	0	0	0	0	348	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	19,850	0	10,781	0	30,631	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):*	(50,836)	0	0	0	0	0	0	0	0	0	0	(50,836)	43
44	TOTAL Special Cost Centers	(50,836)	0	0	0	0	0	0	0	0	0	0	(50,836)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(77,773)	35,610	47,238	0	5,075	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
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,491	\$ 1,491	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	73	73	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	66	66	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%			4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	276	276	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,792	3,792	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	598	598	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,390	5,390	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	495	495	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,666	1,666	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	14,695	14,695	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,435	6,435	12
13	V	20 Due, Fees, Su bs & Promos		Petersen Health Care, Inc.	100.00%	633	633	13
14	Total		\$			\$ 35,610	\$ * 35,610	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 23,688	\$	23,688	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	192		192	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,736		5,736	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,526		1,526	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,129		1,129	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,186		4,186	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,840		5,840	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,244		3,244	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	685		685	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	664		664	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	348		348	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		\$			\$ 47,238	\$ *	47,238	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.92	1.84	Salary	\$ 14,694	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,694		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

Facility Name & ID Number Eastview Terrace

0046060 Report Period Beginning:

01/01/06

Ending: 12/31/06

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, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	20,967	\$ 1,491	1
2	2	Food	Patient Days	1,141,463	56	3,989	0	20,967	73	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	0	20,967	66	3
4	4	Laundry	Patient Days	1,141,463	56	0	0	20,967	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	0	20,967	277	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	20,967	3,792	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	0	20,967	597	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	20,967	5,390	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	0	20,967	495	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	0	20,967	1,666	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	20,967	14,695	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	0	20,967	6,437	12
13	20	Due, Fees, Su bs & Promos	Patient Days	1,141,463	56	34,325	0	20,967	630	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	20,967	23,688	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	0	20,967	192	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	0	20,967	5,736	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	0	20,967	1,526	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	0	20,967	1,129	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	0	20,967	4,186	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	0	20,967	5,841	20
21	32	Interest	Patient Days	1,141,463	56	176,614	0	20,967	3,244	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	0	20,967	685	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	0	20,967	664	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	0	20,967	348	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999		\$ 82,848	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/06 Ending: 12/31/06

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										
										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	LaSalle Bank		X	Mortgage	Varies	08/31/02	\$ 1,887,097	\$ 1,768,360	08/31/07	Varies	\$ 134,089	1							
2												2							
3												3							
4							Offset interest income				(3,919)	4							
5							Allocated from Home Office				3,244	5							
Working Capital																			
6	LaSalle Bank		X	Working Capital	Interest	08/31/02	150,000		LOC	Varies	9,388	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 2,037,097	\$ 1,768,360			\$ 142,802	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 2,037,097	\$ 1,768,360			\$ 142,802	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046060

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. <u>08-08-01-202037</u>	<u>Nursing Home</u>	\$ <u>12,643.28</u>	\$ <u>12,643.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>12,643.28</u>	\$ <u>12,643.28</u>

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 13,082 B. General Construction Type: Exterior Block Frame Steel Number of Stories 1C. 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/AF. 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/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>217,546</u>	<u>2000</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,546		\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		2000	1976	\$ 982,565	\$	39	\$ 25,194	\$ 25,194	\$ 174,468	4
5	6		2000	1985							5
6	Allocation										6
7	From Home			2006	12,505			547	547		7
8	Office										8
	Improvement Type**										
9	Water Heater		2000		4,800		7	686	686	3,486	9
10	Concrete Pad		2000		500		20	25	25	98	10
11	Painting Exterior Building		2000		2,480		5	496	496	1,881	11
12	Fence		2000		3,953		15	264	264	1,631	12
13	Asphalt Parking Lot		2000		2,370		15	158	158	790	13
14	Carpet		2000		503		7	72	72	332	14
15	Flooring		2001		72,265		39	1,853	1,853	12,491	15
16	Remodeling		2001		6,245		39	160	160	1,097	16
17	Roofing		2001		2,159		39	55	55	367	17
18	Roofing		2001		12,000		39	308	308	1,908	18
19	Replacement - Glass		2001		1,179		7	168	168	639	19
20	Medicare wing upgrade		2002		89,018		39	2,283	2,283	12,923	20
21	Roofing		2002		14,200		39	364	364	2,021	21
22	Flooring		2002		4,263		39	109	109	595	22
23	Architects Fee		2002		1,916		39	49	49	246	23
24	Wall hangings		2002		3,220		7	460	460	1,452	24
25	Paving of Parking Lot		2004		4,200		15	280	280	723	25
26	Window Balance		2004		1,714		7	245	245	545	26
27	Driveway renovation		2005		1,100		20	55	55	104	27
28	Grease interceptor		2005		15,589		20	779	779	946	28
29	Sidewalks		2005		4,919		20	246	246	273	29
30	Sealcoating		2006		5,650		8	353	353	353	30
31	Pipe Work		2006		3,700		25	74	74	74	31
32	Land Improvement Booked					562			(562)		32
33	Building Booked					25,194			(25,194)		33
34	Building Improvement Booked					6,805			(6,805)		34
35	2006 Home office allocation - Leasehold improvements				20			1	1	1	35
36	2006 Home office allocation - Land & land improvements				723			67	67	614	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

0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			1,253,756		32,561		35,351	
						2,790	220,058	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 283,990	\$ 26,865	\$ 39,889	\$ 13,024	5-7	\$ 194,143	71
72	Current Year Purchases	3,898		195	195	10	195	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			5,225	5,225			74
75	TOTALS	\$ 287,888	\$ 26,865	\$ 45,309	\$ 18,444		\$ 194,338	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	\$	\$ 8,461	\$ 8,461	5	\$ 33,492	76
77	Resident Care	Malibu 2000	2001	11,054	637	552	(85)	5	11,054	77
78										78
79										79
80	TOTALS			\$ 53,361	\$ 637	\$ 9,013	\$ 8,376		\$ 44,546	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,695,005	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,063	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,673	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,610	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 458,942	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.

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountant's Compilation Report

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	Other: Home Office Allocation			664			5
6							6
7	TOTAL			\$ 664			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: \$ 8,662 Description: Copier - 3,250; Laundry - 200; Truck - 260; Nursing Equipment - 4,604; Home Office - 348

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	336	\$ 26,831	\$	336	\$ 26,831	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		54	4,676		54	4,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		399	30,906		399	30,906	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				23,592		23,592	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			\$	789	\$ 62,413	\$ 23,592	789	\$ 86,005	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,948,898	\$ 1,948,898	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	481,884	481,884	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,250	2,250	6
7	Other Prepaid Expenses	10,769	10,769	7
8	Accounts Receivable (owners or related parties)	(4,040)	(4,040)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,439,761	\$ 2,439,761	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,850	100,000	13
14	Buildings, at Historical Cost	1,224,143	1,253,757	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	347,762	341,248	16
17	Accumulated Depreciation (book methods)	(532,203)	(458,942)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Goodwill</u>)	320,669	320,669	22
23	Other(specify): <u>Due from Mbp</u>	687,672	687,672	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,157,893	\$ 2,244,404	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,597,654	\$ 4,684,165	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 267,592	\$ 267,592	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,279	59,279	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,840	1,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,680	12,680	32
33	Accrued Interest Payable	9,453	9,453	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expense</u>	12,527	12,527	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 363,371	\$ 363,371	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,768,360	1,768,360	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Rounding</u>	2	2	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,768,362	\$ 1,768,362	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,131,733	\$ 2,131,733	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,465,921	\$ 2,552,432	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,597,654	\$ 4,684,165	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,960,784	1
2	Restatements (describe):		2
3	Post-Cost Report audit adjustments	(3,253)	3
4	Rounding	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,957,527	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	508,394	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)	\$ 508,394	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)	\$ 2,465,921	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 2,249,020	1
2	Discounts and Allowances for all Levels	23,667	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,272,687	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,115	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 110,115	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	1,348	14
15	Telephone, Television and Radio	2,656	15
16	Rental of Facility Space		16
17	Sale of Drugs	93,329	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,893	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 103,226	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,919	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,919	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Rev \$500 \ Misc Rev \$3,735	4,235	28
28a	Medicare Part A Bad Debt Reimb.	28,123	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,358	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,522,305	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	511,343	31
32	Health Care	875,242	32
33	General Administration	294,503	33
B. Capital Expense			
34	Ownership	224,679	34
C. Ancillary Expense			
35	Special Cost Centers	73,652	35
36	Provider Participation Fee	34,494	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	(2)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,013,911	40
41	Income before Income Taxes (line 30 minus line 40)**	508,394	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 508,394	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.
This entity is a cash basis taxpayer.

*** 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

0046060

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,733	1,929	\$ 47,386	\$ 24.56	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	3,037	3,230	59,541	18.43	3
4	Licensed Practical Nurses	12,283	12,966	202,067	15.58	4
5	CNAs & Orderlies	30,990	32,397	309,045	9.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,061	2,109	18,239	8.65	9
10	Activity Assistants			0		10
11	Social Service Workers	2,080	2,080	27,348	13.15	11
12	Dietician			0		12
13	Food Service Supervisor	2,080	2,080	33,589	16.15	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	13,134	14,027	115,652	8.24	15
16	Dishwashers					16
17	Maintenance Workers	2,085	2,085	23,605	11.32	17
18	Housekeepers	7,689	7,960	52,424	6.59	18
19	Laundry	5,161	5,342	39,518	7.40	19
20	Administrator	2,167	2,287	51,879	22.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	23,242	11.17	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Care Plan Coord.	2,080	2,080	40,019	19.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,661	92,653	\$ 1,043,554 *	\$ 11.26	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	24	\$ 1,260	1(3)	35
36	Medical Director	Monthly	9,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	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				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	1 visit	75	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	\$ 12,035		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 01/01/06

Ending: 12/31/06

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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,637 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,494
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,423 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 42,585
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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 in progress
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT