



Facility Name & ID Number Eastview Terrace

# 0046060 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**III. STATISTICAL DATA**

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,689</u>	<u>3,737</u>	<u>2,240</u>	<u>20,666</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	<b>TOTALS</b>	<u>14,689</u>	<u>3,737</u>	<u>2,240</u>	<u>20,666</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.87%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  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 9 and days of care provided 2,240

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	151,979	12,373	3,360	167,712		167,712	1,729	169,441		1
2	Food Purchase		154,729		154,729		154,729	(36,642)	118,087		2
3	Housekeeping	74,149	21,538		95,687		95,687	20	95,707		3
4	Laundry	33,129	18,639		51,768		51,768	1	51,769		4
5	Heat and Other Utilities			66,547	66,547		66,547	295	66,842		5
6	Maintenance	24,468	2,089	21,618	48,175		48,175	2,409	50,584		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							789	789		7
8	<b>TOTAL General Services</b>	283,725	209,368	91,525	584,618		584,618	(31,399)	553,219		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	629,759	56,383	2,337	688,479		688,479	4,573	693,052		10
10a	Therapy			126,957	126,957		126,957		126,957		10a
11	Activities	16,470	426	1,096	17,992		17,992		17,992		11
12	Social Services	37,370			37,370		37,370		37,370		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,017	1,017		15
16	<b>TOTAL Health Care and Programs</b>	683,599	56,809	141,390	881,798		881,798	5,590	887,388		16
	<b>C. General Administration</b>										
17	Administrative	35,045			35,045		35,045	12,873	47,918		17
18	Directors Fees										18
19	Professional Services			18,340	18,340		18,340	3,495	21,835		19
20	Dues, Fees, Subscriptions & Promotions			9,452	9,452		9,452	382	9,834		20
21	Clerical & General Office Expenses	23,301	4,046	10,859	38,206		38,206	29,030	67,236		21
22	Employee Benefits & Payroll Taxes			128,131	128,131		128,131		128,131		22
23	Inservice Training & Education			162	162		162	337	499		23
24	Travel and Seminar							537	537		24
25	Other Admin. Staff Transportation			6,459	6,459		6,459	1,944	8,403		25
26	Insurance-Prop.Liab.Malpractice			18,427	18,427		18,427	791	19,218		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,382	8,382		27
28	<b>TOTAL General Administration</b>	58,346	4,046	191,830	254,222		254,222	57,771	311,993		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,025,670	270,223	424,745	1,720,638		1,720,638	31,962	1,752,600		29

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

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

Facility Name & ID Number Eastview Terrace

#0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			52,202	52,202		52,202	28,098	80,300			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			257,152	257,152		257,152	3,151	260,303			32
33	Real Estate Taxes			12,863	12,863		12,863	676	13,539			33
34	Rent-Facility & Grounds							42	42			34
35	Rent-Equipment & Vehicles			5,678	5,678		5,678	545	6,223			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			327,895	327,895		327,895	32,512	360,407			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,752		59,752		59,752		59,752			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):* Non-allowable Cost		587	134,928	135,515		135,515	(135,515)				43
44	<b>TOTAL Special Cost Centers</b>		60,339	169,421	229,760		229,760	(135,515)	94,245			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,025,670	330,562	922,061	2,278,293		2,278,293	(71,041)	2,207,252			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.

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36,702)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,965)	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	26,045	30		9
10	Interest and Other Investment Income	(417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(318)	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	(20,000)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,182)	43		24
25	Fund Raising, Advertising and Promotional	(5,601)	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	(11,107)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (147,247)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	76,206	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 76,206</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (71,041)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

Eastview Terrace

ID# 0046060

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,594)	43	1
2	X-Rays-Part A	(1,522)	43	2
3	Offset Disallowed Dues	(375)	20	3
4	Resident Flowers	(328)	43	4
5	Disallowed Special Events	(6,005)	43	5
6	Offset of Miscellaneous Income	(283)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(11,107)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	1,729	0	0	0	0	0	0	0	0	0	1,729	1
2	Food Purchase	(36,702)	60	0	0	0	0	0	0	0	0	0	(36,642)	2
3	Housekeeping	0	20	0	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	295	0	0	0	0	0	0	0	0	0	295	5
6	Maintenance	0	2,409	0	0	0	0	0	0	0	0	0	2,409	6
7	Other (specify):*	0	789	0	0	0	0	0	0	0	0	0	789	7
8	<b>TOTAL General Services</b>	<b>(36,702)</b>	<b>5,303</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(31,399)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,573	0	0	0	0	0	0	0	0	0	4,573	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	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	1,017	0	0	0	0	0	0	0	0	0	1,017	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5,590</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,590</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	12,873	0	0	0	0	0	0	0	0	0	12,873	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,495	0	0	0	0	0	0	0	0	0	3,495	19
20	Fees, Subscriptions & Promotions	(375)	0	757	0	0	0	0	0	0	0	0	382	20
21	Clerical & General Office Expenses	(283)	0	29,313	0	0	0	0	0	0	0	0	29,030	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	337	0	0	0	0	0	0	0	0	337	23
24	Travel and Seminar	0	0	537	0	0	0	0	0	0	0	0	537	24
25	Other Admin. Staff Transportation	0	0	1,944	0	0	0	0	0	0	0	0	1,944	25
26	Insurance-Prop.Liab.Malpractice	0	0	791	0	0	0	0	0	0	0	0	791	26
27	Other (specify):*	0	0	8,382	0	0	0	0	0	0	0	0	8,382	27
28	<b>TOTAL General Administration</b>	<b>(658)</b>	<b>16,368</b>	<b>42,061</b>	<b>0</b>	<b>57,771</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(37,360)</b>	<b>27,261</b>	<b>42,061</b>	<b>0</b>	<b>31,962</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	26,045	0	2,053	0	0	0	0	0	0	0	0	28,098	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(417)	0	3,568	0	0	0	0	0	0	0	0	3,151	32
33	Real Estate Taxes	0	0	676	0	0	0	0	0	0	0	0	676	33
34	Rent-Facility & Grounds	0	0	42	0	0	0	0	0	0	0	0	42	34
35	Rent-Equipment & Vehicles	0	0	545	0	0	0	0	0	0	0	0	545	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>25,628</b>	<b>0</b>	<b>6,884</b>	<b>0</b>	<b>32,512</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(135,515)	0	0	0	0	0	0	0	0	0	0	(135,515)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(135,515)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(135,515)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(147,247)</b>	<b>27,261</b>	<b>48,945</b>	<b>0</b>	<b>(71,041)</b>	<b>45</b>							

Facility Name & ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,729	\$ 1,729	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	60	60	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	20	20	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	295	295	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,409	2,409	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	789	789	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,573	4,573	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,017	1,017	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	12,873	12,873	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,495	3,495	12	
13	V							13	
14	Total		\$			\$ 27,261	\$ *	27,261	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 757	\$	757	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,313		29,313	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	337		337	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	537		537	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,944		1,944	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	791		791	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,382		8,382	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,053		2,053	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,568		3,568	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	676		676	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	42		42	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	545		545	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 48,945	\$ *	48,945	39

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

Facility Name & ID Number Eastview Terrace# 0046060Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 <u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$	\$	0	15	
16	V	2 <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%				16	
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%				17	
18	V	4 <u>Laundry</u>		<u>Petersen Health Care, Inc.</u>	100.00%				18	
19	V	5 <u>Utilities</u>		<u>Petersen Health Care, Inc.</u>	100.00%				19	
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%				20	
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%				21	
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%				22	
23	V	10A <u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%				23	
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%				24	
25	V	17 <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%				25	
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%				26	
27	V	20 <u>Dues, Fees, Subs and Prmotions</u>		<u>Petersen Health Care, Inc.</u>	100.00%				27	
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%				28	
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%				29	
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%				30	
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%				31	
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%				32	
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%				33	
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%				34	
35	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%				35	
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%				36	
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%				37	
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%				38	
39	Total		\$			\$	\$	0	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							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	<b>Total</b>		\$			\$	0	\$ *

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

Facility Name &amp; ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	0.85	1.54	Salary	\$ 12,873	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	\$ 12,873		13

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

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

Facility Name & ID Number Eastview Terrace

# 0046060 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	0	66	\$ 110,171	\$ 109,587	20,812	\$ 1,729	1
2	2	Food	Resident Days	0	66	3,806	0	20,812	60	2
3	3	Housekeeping	Resident Days	0	66	1,250	0	20,812	20	3
4	4	Laundry	Resident Days	0	66	73	0	20,812	1	4
5	5	Utilities	Resident Days	0	66	18,812	0	20,812	295	5
6	6	Maintenance	Resident Days	0	66	153,468	113,063	20,812	2,409	6
7	7	Mgmt. Allocation of Benefits	Resident Days	0	66	50,271	0	20,812	789	7
8	10	Nursing and Medical Records	Resident Days	0	66	291,305	286,855	20,812	4,573	8
9	10A	Therapy	Resident Days	0	66	0	0	20,812	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	0	66	64,765	0	20,812	1,017	10
11	17	Administrative	Resident Days	0	66	820,116	820,116	20,812	12,873	11
12	19	Professional Services	Resident Days	0	66	222,628	0	20,812	3,495	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	0	66	48,243	0	20,812	757	13
14	21	Clerical and General Office	Resident Days	0	66	1,867,440	1,544,801	20,812	29,313	14
15	23	Inservice Training & Education	Resident Days	0	66	21,481	0	20,812	337	15
16	24	Travel and Seminar	Resident Days	0	66	34,177	0	20,812	537	16
17	25	Other Admin. Staff Transport.	Resident Days	0	66	123,847	0	20,812	1,944	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	0	66	50,427	0	20,812	791	18
19	27	Mgmt. Allocation of Benefits	Resident Days	0	66	533,953	0	20,812	8,382	19
20	30	Depreciation	Resident Days	0	66	130,767	0	20,812	2,053	20
21	32	Interest	Resident Days	0	66	227,295	0	20,812	3,568	21
22	33	Real Estate Taxes	Resident Days	0	66	43,090	0	20,812	676	22
23	34	Rent-Facility and Grounds	Resident Days	0	66	2,648	0	20,812	42	23
24	35	Rent-Equipment & Vehicles	Resident Days	0	66	34,690	0	20,812	545	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 76,206	25

Facility Name & ID Number

Eastview Terrace

# 0046060

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	LaSalle Bank		X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 3,040,048	12/31/2013	Varies	\$ 256,205	1						
2	Associated Bank		X	2007 Econoline Van	\$580.00	7/23/07	28,328	26,375	7/23/12	0.0828	947	2						
3							Offset interest income				(417)	3						
4							Home Office Allocation				3,568	4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$580.00		\$ 3,103,328	\$ 3,066,423			\$ 260,303	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,103,328	\$ 3,066,423			\$ 260,303	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.)

\*\* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>Long-Term Care Facility</u>	\$ <u>12,544.00</u>	\$ <u>12,544.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>12,544.00</u>	\$ <u>12,544.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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.

Facility Name & ID Number Eastview Terrace

# 0046060

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,082 B. General Construction Type: Exterior Block Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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>Facility</u>	<u>217,546</u>	<u>2000</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>217,546</b>		<b>\$ 100,000</b>	<b>3</b>

Facility Name &amp; ID Number Eastview Terrace

# 0046060

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$ 200,502	4
5	6	2000	1985							5
6										6
7	Home Office Allocation			11,521			281	281		7
8										8
	<b>Improvement Type**</b>									
9	Water Heater		2000	4,800		7	686	686	4,172	9
10	Concrete Pad		2000	500		20	25	25	123	10
11	Painting Exterior Building		2000	2,480		5	496	496	2,377	11
12	Fence		2000	3,953		15	264	264	1,895	12
13	Asphalt Parking Lot		2000	2,370		15	158	158	948	13
14	Carpet		2000	503		7	72	72	404	14
15	Flooring		2001	72,265		39	1,853	1,853	14,344	15
16	Remodeling		2001	6,245		39	160	160	1,257	16
17	Roofing		2001	2,159		39	55	55	422	17
18	Roofing		2001	12,000		39	308	308	2,216	18
19	Replacement - Glass		2001	1,179		7	168	168	807	19
20	Medicare wing upgrade		2002	89,018		39	2,283	2,283	15,206	20
21	Roofing		2002	14,200		39	364	364	2,385	21
22	Flooring		2002	4,263		39	109	109	704	22
23	Architects Fee		2002	1,916		39	49	49	295	23
24	Wall hangings		2002	3,220		7	460	460	1,912	24
25	Paving of Parking Lot		2004	4,200		15	280	280	1,003	25
26	Window Balance		2004	1,714		7	245	245	790	26
27	Driveway renovation		2005	1,100		20	55	55	159	27
28	Grease interceptor		2005	15,589		20	779	779	1,725	28
29	Sidewalks		2005	4,919		20	246	246	519	29
30	Sealcoating		2006	5,650		8	706	706	1,059	30
31	Pipe Work		2006	3,700		25	148	148	222	31
32	Sidewalks		2007	4,420		15	147	147	147	32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

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	Building Booked		25,194			(25,194)		52
53	Building Improvement Booked		7,667			(7,667)		53
54								54
55								55
56	2007-Home Office Allocation-Building Improvements	771			46	46		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)	\$ 1,257,220	\$ 32,861		\$ 35,637	\$ 2,776	\$ 255,593	70

\*\*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	\$ 294,402	\$ 16,842	\$ 40,084	\$ 23,242	5-10	\$ 282,367	71
72	Current Year Purchases	5,324	138	138		10	138	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,726	1,726			74
75	TOTALS	\$ 299,726	\$ 16,980	\$ 41,948	\$ 24,968		\$ 282,505	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	\$	\$ 354	\$ 354	5	\$ 42,307	76
77	Resident Care	Malibu 2000	2001	11,054				5	11,054	77
78	Resident Care	Ford Econoline Van 2007	2007	28,328	2,361	2,361		5	2,361	78
79										79
80	TOTALS			\$ 81,689	\$ 2,361	\$ 2,715	\$ 354		\$ 55,722	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)	\$ 1,738,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,202	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,300	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,098	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 593,820	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: N/A

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	<u>Home Office Allocation</u>			<u>42</u>			6
7	TOTAL			\$ <u>42</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 \_\_\_\_\_.

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: \$ 6,223 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

**Eastview Terrace**

**0046060**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Copier	\$	3,196
Dishwasher		30
Nursing Equipment		2,452
Home Office Allocation		545
		<u>6,223</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.

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	L. 10A, C. 3	hrs	\$	2,837	\$ 42,553	\$	2,837	\$ 42,553	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		312	33,427		312	33,427	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		3,398	50,977		3,398	50,977	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescrpts				59,752		59,752	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	<b>TOTAL</b>			\$	6,547	\$ 126,957	\$ 59,752	6,547	\$ 186,709	14

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

Facility Name &amp; ID Number Eastview Terrace

# 0046060

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,839,150	\$ 3,839,150	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	345,919	345,919	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,551	10,551	6
7	Other Prepaid Expenses	6,914	6,914	7
8	Accounts Receivable (owners or related parties)	681,240	681,240	8
9	Other(specify): <u>                                    </u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,883,774	\$ 4,883,774	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,270	100,000	13
14	Buildings, at Historical Cost	982,565	994,086	14
15	Leasehold Improvements, at Historical Cost	241,578	263,134	15
16	Equipment, at Historical Cost	81,415	381,415	16
17	Accumulated Depreciation (book methods)	(584,405)	(593,820)	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>                                    </u>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,456,092	\$ 1,465,484	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,339,866	\$ 6,349,258	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 239,914	\$ 239,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,364	59,364	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,397	2,397	31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,000	13,000	32
33	Accrued Interest Payable	21,614	21,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	13,334	13,334	36
37	<u>Employee Advances</u>	136	136	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 349,759	\$ 349,759	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	26,375	26,375	39
40	Mortgage Payable	3,040,048	3,040,048	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>  </u>			43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 3,066,423	\$ 3,066,423	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,416,182	\$ 3,416,182	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,923,684	\$ 2,933,076	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,339,866	\$ 6,349,258	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,465,921</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,465,921</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>457,763</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>457,763</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,923,684</b>	<b>24</b> *

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

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,226,527	1
2	Discounts and Allowances for all Levels	120,654	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,347,181	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	221,080	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 221,080	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,054	14
15	Telephone, Television and Radio	1,139	15
16	Rental of Facility Space		16
17	Sale of Drugs	112,851	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,930	20
21	Other Medical Services	6,697	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 127,671	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	2,750	24
25	Interest and Other Investment Income***	417	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,167	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	36,957	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 36,957	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,736,056	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	584,618	31
32	Health Care	881,798	32
33	General Administration	254,222	33
	<b>B. Capital Expense</b>		
34	Ownership	327,895	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	195,267	35
36	Provider Participation Fee	34,493	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,278,293	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	457,763	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 457,763	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. Facility is a division of a larger entity.

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

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

Eastview Terrace

0046060

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Other	283
Inmate Meal Revenue	35,648
Transporation	<u>1,026</u>
	<u><u>36,957</u></u>

Facility Name & ID Number Eastview Terrace

# 0046060

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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	1,884	1,908	\$ 42,799	\$ 22.43	1
2	Assistant Director of Nursing	1,300	1,300	23,233	17.87	2
3	Registered Nurses	3,327	3,364	64,179	19.08	3
4	Licensed Practical Nurses	11,165	11,520	191,912	16.66	4
5	CNAs & Orderlies	29,359	30,407	290,571	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,349	1,405	12,699	9.04	9
10	Activity Assistants	404	436	3,771	8.65	10
11	Social Service Workers	2,080	2,080	37,370	17.97	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,520	15.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,690	14,435	119,459	8.28	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	24,468	11.76	17
18	Housekeepers	9,896	10,063	74,149	7.37	18
19	Laundry	4,156	4,370	33,129	7.58	19
20	Administrator	2,080	2,080	35,045	16.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,050	2,050	23,301	11.37	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 C: <u>Care Plan Coord.</u>	867	867	17,065	19.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,767	90,445	\$ 1,025,670 *	\$ 11.34	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	64	\$ 3,360	1(3)	35
36	Medical Director	Monthly	11,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	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) <u>Psychologist</u>	2 visits	375	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	64	\$ 15,335		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Bonnie Hayden	Administrator	0	\$ 35,045	Workers' Compensation Insurance	\$ 17,935	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	19,190	Advertising: Employee Recruitment	411	
				FICA Taxes	76,734	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	12,050	Patient Background Checks	105 1,050	
				Employee Meals		Misc. License & Permits	243	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	757	
				Smoking Cessation	116	Misc. Subscriptions & Dues	375	
				Employee Retirement	1,053	IHCA Dues	4,778	
				Employee Relations	1,053	LTC Solutions License	1,600	
						Less: Public Relations Expense	(375)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 35,045	TOTAL (agree to Schedule V, line 22, col.8)		\$ 9,834		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 0				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				In-State Travel	
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount				Home Office Allocation	
RSM McGladrey	Accounting Services		\$ 6,080				537	
Mediacom	Computer Services		1,000				Entertainment Expense	
E-Health Data Solutions	Computer Services		2,025				( )	
Hughes, Hill, Tenney, LLC	Legal Services		9,235				TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,340	TOTAL			\$ 537	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Eastview Terrace**

**0046060**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
---------------------	-------------	---------------

Total (agree to Schedule V, line 19, column 3)		18,340
--	--	--------

**Home Office Allocation**

Pearl & Associates	Legal	23
Addy Bush & Assoc	Legal	12
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	51
Duane Morris	Legal	78
Ginoli & Co.	Accountants	799
RSM McGladrey	Accountants	138
McGladrey & Pullen	Accountants	211
Emdeon Business Services	Computer Services	55
Advanced Answers on Demand	Computer Services	1,482
Access 2 Go	Computer Services	112
Ivans	Computer Services	98
Kemper Technology	Computer Services	232
Adminastar Federal	Computer Services	29
Logmein	Computer Services	18
E-Health Data Solutions	Computer Services	145
Miscellaneous Vendors	Miscellaneous	10

Total (agree to Schedule V, line 19, column 8)		<u>21,835</u>
--	--	---------------



Facility Name &amp; ID Number Eastview Terrace

# 0046060

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**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. IHCA-\$4,778
- (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. \$ 13,538 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? 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 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, 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 36,702
- (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? N/A
- 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? 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? N/A If no, please explain. Audit still 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 \$5,000, 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