

Facility Name & ID Number Eastview Terrace

0046060 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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>9</u>	Skilled (SNF)	<u>9</u>	<u>3,285</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,710</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF			<u>1,383</u>	<u>1,383</u>	8
9	SNF/PED					9
10	ICF	<u>11,547</u>	<u>3,261</u>	<u>320</u>	<u>15,128</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,547</u>	<u>3,261</u>	<u>1,703</u>	<u>16,511</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.80%

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)
None

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 2/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2000 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 9 and days of care provided 1,383

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: 12/31/2009 Fiscal Year: 12/31/2009

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	145,854	20,452		166,306		166,306	2,887	169,193		1
2	Food Purchase		148,887		148,887		148,887	(78,359)	70,528		2
3	Housekeeping	85,183	23,460		108,643		108,643	27	108,670		3
4	Laundry	22,098	10,835		32,933		32,933		32,933		4
5	Heat and Other Utilities			65,444	65,444		65,444	285	65,729		5
6	Maintenance	26,314	6,114	18,906	51,334		51,334	1,399	52,733		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							521	521		7
8	TOTAL General Services	279,449	209,748	84,350	573,547		573,547	(73,240)	500,307		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	619,719	62,475	230,584	912,778		912,778	1,574	914,352		10
10a	Therapy			96,698	96,698		96,698		96,698		10a
11	Activities	18,077	1,108	859	20,044		20,044		20,044		11
12	Social Services	22,559			22,559		22,559		22,559		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							215	215		15
16	TOTAL Health Care and Programs	660,355	63,583	340,141	1,064,079		1,064,079	1,789	1,065,868		16
	C. General Administration										
17	Administrative	12,000			12,000		12,000	48,077	60,077		17
18	Directors Fees										18
19	Professional Services			22,156	22,156		22,156	4,048	26,204		19
20	Dues, Fees, Subscriptions & Promotions			7,263	7,263		7,263	753	8,016		20
21	Clerical & General Office Expenses	19,065	4,845	6,124	30,034		30,034	29,184	59,218		21
22	Employee Benefits & Payroll Taxes			177,047	177,047		177,047		177,047		22
23	Inservice Training & Education			459	459		459	301	760		23
24	Travel and Seminar							93	93		24
25	Other Admin. Staff Transportation			6,639	6,639		6,639	1,451	8,090		25
26	Insurance-Prop.Liab.Malpractice			22,931	22,931		22,931	602	23,533		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,903	7,903		27
28	TOTAL General Administration	31,065	4,845	242,619	278,529		278,529	92,412	370,941		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	970,869	278,176	667,110	1,916,155		1,916,155	20,961	1,937,116		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.

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Ending:

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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	
	D. Ownership											
30	Depreciation			43,274	43,274		43,274	9,862	53,136			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,120	168,120		168,120	2,122	170,242			32
33	Real Estate Taxes			11,663	11,663		11,663	366	12,029			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,736	7,736		7,736	350	8,086			35
36	Other (specify):*											36
37	TOTAL Ownership			230,793	230,793		230,793	12,700	243,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,468		38,468		38,468		38,468			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	34,586	306	40,245	75,137		75,137	(75,137)				43
44	TOTAL Special Cost Centers	34,586	38,774	74,738	148,098		148,098	(75,137)	72,961			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,005,455	316,950	972,641	2,295,046		2,295,046	(41,476)	2,253,570			45

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

VI. ADJUSTMENT DETAIL

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

		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	(1,606)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,482	30		9
10	Interest and Other Investment Income	(1,538)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(96)	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	(4,619)	43		18
19	Entertainment				19
20	Contributions	(200)	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	(26,277)	43		24
25	Fund Raising, Advertising and Promotional	(38,456)	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	(83,113)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,423)		\$	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)	106,947	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 106,947		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (41,476)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,913)	43	1
2	X-Rays-Part A	(1,326)	43	2
3	Offset Disallowed Dues	(375)	20	3
4	Resident Flowers	(252)	43	4
5	Disallowed Special Events	(1,998)	43	5
6	Offset of Office Supplies Income	(258)	21	6
7	Offset of Nursing Supplies Income	(173)	10	7
8	Offset of Jail Meals Income	(76,818)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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22				22
23				23
24				24
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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	(83,113)		49

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1/1/2009

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12/31/2009

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%	\$ 2,887	\$ 2,887	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	65	65	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	27	27	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	285	285	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,399	1,399	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	521	521	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,747	1,747	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	215	215	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	48,077	48,077	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,048	4,048	12	
13	V							13	
14	Total		\$			\$ 59,271	\$ *	59,271	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%	\$ 1,128	\$	1,128	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,442		29,442	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	301		301	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	93		93	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,451		1,451	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	602		602	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,903		7,903	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,380		2,380	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,660		3,660	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	366		366	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	350		350	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		\$			\$ 47,676	\$ *	47,676	39

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

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Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	157,236	0.64	1.07	Salary	\$ 1,877	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	\$ 1,877		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

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Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	1,493,044	75	\$ 261,102	\$ 259,584	16,511	\$ 2,887	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	16,511	65	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	16,511	27	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	16,511	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	16,511	285	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	16,511	1,399	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	16,511	521	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	16,511	1,747	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	16,511	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	16,511	215	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	16,511	48,077	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	16,511	4,048	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	16,511	1,128	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	16,511	29,442	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	16,511	301	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	16,511	93	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	16,511	1,451	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	16,511	602	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	16,511	7,903	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	16,511	2,380	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	16,511	3,660	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	16,511	366	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	16,511	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	16,511	350	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 106,947	25

Facility Name & ID Number

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0046060

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	Bank of America	X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 2,953,909	12/31/2013	Varies	\$ 166,271	1								
2	Associated Bank	X	2007 Econoline Van	\$580.00	7/23/07	28,328	16,109	7/23/12	0.0828	1,609	2								
3						Interest Income Offset				(1,298)	3								
4						Home Office Allocation-PHC				3,660	4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$580.00		\$ 3,103,328	\$ 2,970,018			\$ 170,242	9								
B. Non-Facility Related*																			
10						Interest Paid on Medicare Withholding				240	10								
11						Interest Offset on Medicare Withholding Interest Paid				(240)	11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 3,103,328	\$ 2,970,018			\$ 170,242	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.)

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1/1/2009 Ending:

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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	TOTALS	217,546		\$ 100,000	3

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 250,890	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater		2000		4,800		7			4,800	9
10	Concrete Pad		2000		500		20	25	25	173	10
11	Painting Exterior Building		2000		2,480		5			2,480	11
12	Fence		2000		3,953		15	264	264	2,423	12
13	Asphalt Parking Lot		2000		2,370		15	158	158	1,264	13
14	Carpet		2000		503		7	27	27	503	14
15	Flooring		2001		72,265		39	1,853	1,853	18,050	15
16	Remodeling		2001		6,245		39	160	160	1,577	16
17	Roofing		2001		2,159		39	55	55	532	17
18	Roofing		2001		12,000		39	308	308	2,832	18
19	Replacement - Glass		2001		1,179		7	168	168	1,143	19
20	Medicare wing upgrade		2002		89,018		39	2,283	2,283	19,772	20
21	Roofing		2002		14,200		39	364	364	3,113	21
22	Flooring		2002		4,263		39	109	109	922	22
23	Architects Fee		2002		1,916		39	49	49	393	23
24	Wall hangings		2002		3,220		7	460	460	2,832	24
25	Paving of Parking Lot		2004		4,200		15	280	280	1,563	25
26	Window Balance		2004		1,714		7	245	245	1,280	26
27	Driveway renovation		2005		1,100		20	55	55	269	27
28	Grease interceptor		2005		15,589		20	779	779	3,283	28
29	Sidewalks		2005		4,919		20	246	246	1,011	29
30	Sealcoating		2006		5,650		8	706	706	2,471	30
31	Pipe Work		2006		3,700		25	148	148	518	31
32	Sidewalks		2007		4,420		15	295	295	737	32
33	Replace Exterior Storage Shed (Including Demolition of Old)		2008		5,000		20	250	250	375	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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			951			(951)		45
46			25,194			(25,194)		46
47			6,867			(6,867)		47
48								48
49								49
50		543			34	34		50
51		8,117			195	195		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		\$ 1,258,588	\$ 33,012		\$ 34,710	\$ 1,698	\$ 325,206	70

**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:

1/1/2009

Ending:

12/31/2009

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	\$ 298,520	\$ 4,282	\$ 10,160	\$ 5,878	5-10 yrs.	\$ 287,481	71
72	Current Year Purchases	4,393	314	220	(94)	10 yrs.	220	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,380	2,380			74
75	TOTALS	\$ 302,913	\$ 4,596	\$ 12,760	\$ 8,164		\$ 287,701	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	\$	\$	\$	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	5,666	5,666		5	13,692	78
79										79
80	TOTALS			\$ 81,689	\$ 5,666	\$ 5,666	\$		\$ 67,053	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)	\$ 1,743,190	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,274	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,136	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,862	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 679,960	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	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.

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,086 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2010 \$ _____
13. _____ /2011 \$ _____
14. _____ /2012 \$ _____

* 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
Period End

1/1/2009
12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	3,010
Copier		4,726
Home Office Allocation		350
		<u>8,086</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?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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	10A(3)	hrs	\$	2,440	\$ 36,601	\$	2,440	\$ 36,601	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,449	21,728		1,449	21,728	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,558	38,369		2,558	38,369	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				38,468		38,468	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	6,447	\$ 96,698	\$ 38,468	6,447	\$ 135,166	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 & ID Number Eastview Terrace# 0046060Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 4,333,303	\$ 4,333,303	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>6,000</u>)	309,046	309,046	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,798	32,798	6
7	Other Prepaid Expenses	12,293	12,293	7
8	Accounts Receivable (owners or related parties)	687,672	687,672	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,375,112	\$ 5,375,112	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114,270	100,000	13
14	Buildings, at Historical Cost	982,565	990,682	14
15	Leasehold Improvements, at Historical Cost	246,578	267,906	15
16	Equipment, at Historical Cost	391,116	384,602	16
17	Accumulated Depreciation (book methods)	(672,879)	(679,960)	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 (spe <u>Goodwill</u>)	320,669	320,669	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,382,319	\$ 1,383,899	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,757,431	\$ 6,759,011	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 364,780	\$ 364,780	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,234	60,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,666	1,666	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,500	12,500	32
33	Accrued Interest Payable	15,100	15,100	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	46,076	46,076	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 500,356	\$ 500,356	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,109	16,109	39
40	Mortgage Payable	2,953,909	2,953,909	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	14,104	14,104	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,984,122	\$ 2,984,122	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,484,478	\$ 3,484,478	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,272,953	\$ 3,274,533	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,757,431	\$ 6,759,011	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,272,518	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,272,516	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	437	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)	\$ 437	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)	\$ 3,272,953	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	\$ 1,883,115	1
2	Discounts and Allowances for all Levels	90,023	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,973,138	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,125	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,125	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	1,606	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	71,496	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,736	20
21	Other Medical Services	1,835	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 78,673	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,298	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,298	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	431	28
28a	Jail Meals Revenue	76,818	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 77,249	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,295,483	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	573,547	31
32	Health Care	1,064,079	32
33	General Administration	278,529	33
B. Capital Expense			
34	Ownership	230,793	34
C. Ancillary Expense			
35	Special Cost Centers	113,605	35
36	Provider Participation Fee	34,493	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,295,046	40
41	Income before Income Taxes (line 30 minus line 40)**	437	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 437	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 part of 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.

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	781	813	\$ 17,703	\$ 21.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,659	2,734	54,718	20.01	3
4	Licensed Practical Nurses	8,159	8,423	165,837	19.69	4
5	CNAs & Orderlies	30,423	31,203	307,756	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,529	1,529	15,787	10.33	9
10	Activity Assistants	208	208	2,290	11.01	10
11	Social Service Workers	2100	2,180	22,559	10.35	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,302	25,195	10.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,662	14,307	120,659	8.43	15
16	Dishwashers					16
17	Maintenance Workers	2,062	2,102	26,314	12.52	17
18	Housekeepers	9,843	10,009	85,183	8.51	18
19	Laundry	2,762	2,792	22,098	7.91	19
20	Administrator	1,906	1,906	58,200	30.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,782	1,873	19,065	10.18	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	140	140	1,408	10.06	31
32	Other Health C: CPC	3,400	3,464	72,297	20.87	32
33	Other(specify) Marketing	2,080	2,080	34,586	16.63	33
34	TOTAL (lines 1 - 33)	85,552	88,065	\$ 1,051,655 *	\$ 11.94	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	\$		35
36	Medical Director	Monthly 12,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 599	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)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,599		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	654 \$ 30,202	10(3)	50
51	Licensed Practical Nurses	6,570 160,909	10(3)	51
52	Certified Nurse Assistants/Aides	1,594 35,195	10(3)	52
53	TOTAL (lines 50 - 52)	8,817 \$ 226,307		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Nancy Jones	Administrator	0	15,800	Workers' Compensation Insurance	\$ 30,918	IDPH License Fee	\$ 1,990	
Shannon Paden	Administrator	0	42,400	Unemployment Compensation Insurance	17,533	Advertising: Employee Recruitment	1,981	
				FICA Taxes	77,289	Health Care Worker Background Check		
				Employee Health Insurance	49,992	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	107	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	347	
				Employee Relations	1,092	Miscellaneous Dues & Subscriptions	375	
				Employee Retirement	223	IHCA Dues	1,500	
				Employee Life Insurance		Home Office Allocation	1,128	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 58,200					
B. Administrative - Other								
Description			Amount					
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
LTC Solutions	Computer Services		\$ 1,700				Out-of-State Travel	\$
Mediacom	Computer Services		1,205					
E-Health Data Solutions	Computer Services		2,700					
Hughes, Hill, Tenney, LLC	Legal Services		16,253	N/A			In-State Travel	
Anchor Reporting	Legal Services		217					
Simple LTC	Computer Services		81				Seminar Expense	
							Home Office Allocation	93
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 22,156				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 93

* Attach copy of IMRF notifications

**See instructions.

Eastview Terrace

0046060

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		22,156

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	26
GoffWilson, P.A.	Legal	37
Jackson Lewis	Legal	290
Peter Gartelos	Legal	28
Misc.	Legal	25
Ginoli & Company	Accountants	644
Miscellaneous Vendors	Computer Services	27
Emdeon Business Services	Computer Services	12
Advanced Answers on Demand	Computer Services	1,555
Access 2 Go	Computer Services	150
Ivans	Computer Services	18
Kemper Technology	Computer Services	423
VisionShare	Computer Services	132
MediFax	Computer Services	54
LogmeIn	Computer Services	23
Charter Communications	Computer Services	1
Simple LTC	Computer Services	359
Miscellaneous Vendors	Miscellaneous	244
Total (agree to Schedule V, line 19, column 8)		<u><u>26,204</u></u>

Eastview Terrace
0046060

Period Beginning
Period End

1/1/2009
12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Hughes, Hill and Tenney	37.50	100%	38
Hughes, Hill and Tenney	270.00	100%	270
Anchor Reporting	217.00	100%	217
Hughes, Hill and Tenney	695.20	100%	695
Hughes, Hill and Tenney	2,842.50	100%	2,843
Hughes, Hill and Tenney	255.00	100%	255
Hughes, Hill and Tenney	5,000.00	100%	5,000
Hughes, Hill and Tenney	2,914.25	100%	2,914
Hughes, Hill and Tenney	4,238.45	100%	4,238
Home Office Allocation			
Heyl, Royster, Voelker, Allen	2,414.77	1.08%	26
GoffWilson, P.A.	3,425.00	1.08%	37
Jackson Lewis	27,043.20	1.08%	292
Peter Gartelos	2,612.50	1.08%	28
Misc.	2,327.62	1.08%	25
Total Legal Fees			<u>16,878</u>

Facility Name & ID Number Eastview Terrace# 0046060Report Period Beginning: 1/1/2009Ending: 12/31/2009**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. 1,500 IHCA
- (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? No
- (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. \$ 9,968 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/A
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. \$ 78,424
- (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. \$ No
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.