

Facility Name & ID Number Eastview Terrace

0053009 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,652</u>	<u>2,692</u>	<u>2,067</u>	<u>18,411</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,652</u>	<u>2,692</u>	<u>2,067</u>	<u>18,411</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.07%

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

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 2/1/200 NO

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

YES NO If YES, enter number of beds certified 63 and days of care provided 1,678

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	137,576	13,096	1,048	151,720		151,720	3,568	155,288		1
2	Food Purchase		141,577		141,577		141,577	(27,786)	113,791		2
3	Housekeeping	105,661	13,605		119,266		119,266	28	119,294		3
4	Laundry		10,354	82,368	92,722		92,722		92,722		4
5	Heat and Other Utilities			71,971	71,971		71,971	205	72,176		5
6	Maintenance	27,044	13,164	19,131	59,339		59,339	1,415	60,754		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	270,281	191,796	174,518	636,595		636,595	(22,570)	614,025		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	803,854	74,731	15,270	893,855		893,855	(34)	893,821		10
10a	Therapy			210,294	210,294		210,294		210,294		10a
11	Activities	25,724	6	22,822	48,552		48,552		48,552		11
12	Social Services	17,997			17,997		17,997		17,997		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	847,575	74,737	260,386	1,182,698		1,182,698	(34)	1,182,664		16
	C. General Administration										
17	Administrative			207,500	207,500		207,500	(151,747)	55,753		17
18	Directors Fees										18
19	Professional Services			9,656	9,656		9,656	11,255	20,911		19
20	Dues, Fees, Subscriptions & Promotions			4,800	4,800		4,800	414	5,214		20
21	Clerical & General Office Expenses	28,185	3,387	8,613	40,185		40,185	39,982	80,167		21
22	Employee Benefits & Payroll Taxes			147,495	147,495		147,495	26,856	174,351		22
23	Inservice Training & Education							275	275		23
24	Travel and Seminar							63	63		24
25	Other Admin. Staff Transportation			1,683	1,683		1,683	2,808	4,491		25
26	Insurance-Prop.Liab.Malpractice			29,629	29,629		29,629	431	30,060		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	28,185	3,387	409,376	440,948		440,948	(69,663)	371,285		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,146,041	269,920	844,280	2,260,241		2,260,241	(92,267)	2,167,974		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			55,043	55,043		55,043	5,285	60,328			30
31	Amortization of Pre-Op. & Org.							7,733	7,733			31
32	Interest			64,552	64,552		64,552	10,948	75,500			32
33	Real Estate Taxes			22,997	22,997		22,997	468	23,465			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,389	3,389		3,389	542	3,931			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			145,981	145,981		145,981	24,976	170,957			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,858		63,858		63,858		63,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,873	134,873		134,873		134,873			42
43	Other (specify):* Home Office Ben. Allocati		750	112,052	112,802		112,802	(112,802)				43
44	TOTAL Special Cost Centers		64,608	246,925	311,533		311,533	(112,802)	198,731			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,146,041	334,528	1,237,186	2,717,755		2,717,755	(180,093)	2,537,662			45

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

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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	(3,687)	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	(1,821)	30		9
10	Interest and Other Investment Income	(608)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(235)	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	(102,034)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,024)	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 Page 5A	(33,095)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,504)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(36,589)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,589)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (180,093)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Eastview Terrace

ID# 0053009

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (4,741)	43	1
2	X-Rays-Part A	(3,705)	43	2
3	Resident Flowers	(32)	43	3
4	Offset of Office Supplies Income	(20)	21	4
5	Offset of Jail Meals Income	(24,105)	2	5
6	Offset of Chamber of Commerce Dues	(318)	20	6
7	Disallowed Special Events	(25)	43	7
8	Offset of Nursing Supplies Income	(143)	10	8
9	Disallowed Pet Expense	(6)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(33,095)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		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%	0		10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	180	180	12	
13	V							13	
14	Total		\$			\$ 180	\$ *	180	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 48	\$	48	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	698		698	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			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		\$			\$ 746	\$ *	746	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	1 Dietary	\$	Petersen Health Quality, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Quality, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Quality, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Quality, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Quality, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Quality, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Quality, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Quality, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Quality, LLC	100.00%	4,764	4,764	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	571	571	26	
27	V	21 Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Quality, LLC	100.00%	104	104	28	
29	V	23 Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Quality, LLC	100.00%	7,733	7,733	34	
35	V	32 Interest		Petersen Health Quality, LLC	100.00%	11,349	11,349	35	
36	V	33 Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Quality, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Quality, LLC	100.00%	0		38	
39	Total		\$			\$ 24,521	\$ *	24,521	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	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,568	\$ 3,568
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	6	6
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	28	28
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	205	205
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,415	1,415
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	109	109
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	207,500	Petersen Health Care Management, Inc.	100.00%	55,753	(151,747)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	6,311	6,311
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	113	113
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	40,002	40,002
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	26,752	26,752
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	275	275
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	63	63
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,808	2,808
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	431	431
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	6,408	6,408
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	207	207
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	468	468
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	542	542
39	Total		\$ 207,500			\$ 145,464	\$ * (62,036)

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

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4								4
5								5
6								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

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	18,411	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	18,411	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	18,411	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	18,411	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	18,411	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	18,411	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	18,411	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	18,411	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	18,411	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	18,411	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	18,411	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	18,411	180	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	18,411	48	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	18,411	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	18,411	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	18,411	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	18,411	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	18,411	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	18,411	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	18,411	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	18,411	698	21
22	32	Interest	Resident Days	1,553,881	75	0	0	18,411	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	18,411	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	18,411	0	24
25	TOTALS					\$ 78,110	\$		\$ 926	25

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

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	88,147	6	\$	18,411	\$	1
2	2	Food	Resident Days	88,147	6		18,411		2
3	3	Housekeeping	Resident Days	88,147	6		18,411		3
4	4	Laundry	Resident Days	88,147	6		18,411		4
5	5	Utilities	Resident Days	88,147	6		18,411		5
6	6	Maintenance	Resident Days	88,147	6		18,411		6
7	7	Mgmt. Allocation of Benefits	Resident Days	88,147	6		18,411		7
8	10	Nursing and Medical Records	Resident Days	88,147	6		18,411		8
9	15	Mgmt. Allocation of Benefits	Resident Days	88,147	6		18,411		9
10	17	Administrative	Resident Days	88,147	6		18,411		10
11	19	Professional Services	Resident Days	88,147	6	22,808	18,411	4,764	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	88,147	6	2,735	18,411	571	12
13	21	Clerical and General Office	Resident Days	88,147	6		18,411		13
14	22	Employee Benefits & Payroll	Resident Days	88,147	6	498	18,411	104	14
15	23	Inservice Training & Education	Resident Days	88,147	6		18,411		15
16	24	Travel and Seminar	Resident Days	88,147	6		18,411		16
17	25	Other Admin. Staff Transport.	Resident Days	88,147	6		18,411		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	88,147	6		18,411		18
19	27	Mgmt. Allocation of Benefits	Resident Days	88,147	6		18,411		19
20	31	Amortization	Resident Days	88,147	6	37,023	18,411	7,733	20
21	32	Interest	Resident Days	88,147	6	54,335	18,411	11,349	21
22	33	Real Estate Taxes	Resident Days	88,147	6		18,411		22
23	34	Rent-Facility and Grounds	Resident Days	88,147	6		18,411		23
24	35	Rent-Equipment & Vehicles	Resident Days	88,147	6		18,411		24
25	TOTALS					\$ 117,399	\$	\$ 24,521	25

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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

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	1,553,881	75	\$ 301,135	\$ 292,840	18,411	\$ 3,568	1
2	2	Food	Resident Days	1,553,881	75	480		18,411	6	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	18,411	28	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		18,411	205	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	18,411	1,415	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			18,411		6
7	9	Medical Director	Resident Days	1,553,881	75			18,411		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		18,411	109	8
9	10A	Therapy	Resident Days	1,553,881	75			18,411		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			18,411		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	18,411	55,753	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		18,411	6,311	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		18,411	113	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	18,411	40,002	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		18,411	26,752	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		18,411	275	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		18,411	63	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		18,411	2,808	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		18,411	431	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			18,411		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		18,411	6,408	21
22	32	Interest	Resident Days	1,553,881	75	17,439		18,411	207	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		18,411	468	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		18,411	542	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 145,464	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	Private Bank		X	Mortgage	Varies	10/31/14	\$ 1,482,681	\$ 1,463,753	11/1/39	Varies	\$ 64,552						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 1,482,681	\$ 1,463,753			\$ 64,552						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,948						
15	TOTALS (line 9+line14)						\$ 1,482,681	\$ 1,463,753			\$ 75,500						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	<u>23,448</u>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>22,877</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(571)		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>23,568</u>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	Home Office Allocation 468		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>23,465</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>12,459</u>	8		
	2011	<u>21,426</u>	9		
	2012	<u>21,909</u>	10		
	2013	<u>22,766</u>	11		
	2014	<u>22,877</u>	12		
<u>Accrual based on prior year tax bill.</u>					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2014 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

0053009 Report Period Beginning:

1/1/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082 B. General Construction Type: Exterior Brick 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: 95,556 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 7,733 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>217,546</u>	<u>2000</u>	<u>\$ 100,000</u>	1
2					2
3	TOTALS	<u>217,546</u>		<u>\$ 100,000</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 402,054	4
5	6	2000	1985							5
6										6
7										7
8										8
Improvement Type**										
9	Concrete Pad	2000		500		20	25	25	323	9
10	Fence	2000		3,953		15	210	210	3,953	10
11	Carpet	2000		503		7			503	11
12	Flooring	2001		72,265		39	1,853	1,853	29,168	12
13	Remodeling	2001		6,245		39	160	160	2,537	13
14	Medicare wing upgrade	2002		88,301		39	2,283	2,283	33,470	14
15	Roofing	2002		14,200		39	364	364	5,297	15
16	Window Balance	2004		1,714		7			1,714	16
17	Grease interceptor	2005		15,589		20	779	779	7,957	17
18	Sidewalks	2005		4,919		20	246	246	2,487	18
19										19
20	Pipe Work	2006		3,700		25	148	148	1,406	20
21	Sidewalks	2007		4,420		15	295	295	2,507	21
22	Replace Exterior Storage Shed (Including Demolition of Old)	2008		5,000		20	250	250	1,875	22
23	Wall Flashing-Dining Room	2011		4,700		15	314	314	1,413	23
24	Sprinkler System Replacement	2011		45,990		15	3,066	3,066	7,665	24
25	Parking Lot Grading	2013		3,250		7	464	464	1,160	25
26	Vinyl Flooring-Hallways, Common Area, and Offices	2013		29,569		25	1,182	1,182	2,955	26
27	Wandering Alert System	2014		4,295		7	614	614	921	27
28	Block Wall Repair	2014		3,800		7	543	543	815	28
29	Parking Lot Repaving	2014		44,457		15	2,963	2,963	4,445	29
30	Roof Replacement-North and West Section	2014		39,850		25	1,594	1,594	2,391	30
31										31
32	Irrigation Installation	2014		4,790		15	319	319	479	32
33	Cabinet and Countertop Replacement	2014		2,865		15	191	191	287	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

Facility Name & ID Number Eastview Terrace

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Window Replacement-North and West Section	2014	18,199		15	1,213	\$ 1,213	\$ 1,820	37
38 Repairs and Downspout Replacement-South Section	2014	16,192		15	1,079	1,079	1,619	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63 Land Improvements Booked			951			(951)		63
64 Building Booked			25,194			(25,194)		64
65 Building Improvement Booked			20,490			(20,490)		65
66								66
67 2015-Home Office Allocation-Building Improvements		8,056			193	193		67
68 2015-Home Office Allocation-Land Improvements		752			48	48		68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,430,639	\$ 46,635		\$ 45,590	\$ (1,045)	\$ 521,221	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 72,929	\$ 7,943	\$ 7,238	\$ (705)	5-10 yrs.	\$ 25,970	71
72	Current Year Purchases	3,548	465	177	(288)	10 yrs.	177	72
73	Fully Depreciated Assets	283,990					283,990	73
74	Home Office Allocation			6,865	6,865			74
75	TOTALS	\$ 360,467	\$ 8,408	\$ 14,280	\$ 5,872		\$ 310,137	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Ford Econoline Van 2007	2007	28,328	\$	\$	\$		\$ 28,328	76
77										77
78										78
79										79
80	TOTALS			\$ 28,328	\$	\$	\$		\$ 28,328	80

E. Summary of Care-Related Assets

		1 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)	\$ 1,919,434	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,870	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,827	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 859,686	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

0053009

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 3,931 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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Eastview Terrace
0053009
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	1,573
Dishwasher	\$	58
Copier		1,758
Home Office Allocation		<u>542</u>
		<u><u>3,931</u></u>

Facility Name & ID Number Eastview Terrace # 0053009 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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>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	\$	5,527	\$ 82,903	\$	5,527	\$ 82,903	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,707	25,602		1,707	25,602	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,786	101,789		6,786	101,789	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				63,858		63,858	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			\$	14,020	\$ 210,294	\$ 63,858	14,020	\$ 274,152	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# 0053009Report Period Beginning: 1/1/2015Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	\$ 164,891	\$ 164,891	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>170,315</u>)	515,392	515,392	3
4	Supply Inventory (priced at <u>Cost</u>)	12,293	12,293	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,346	24,346	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 716,922	\$ 716,922	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	990,621	14
15	Leasehold Improvements, at Historical Cost	470,035	451,168	15
16	Equipment, at Historical Cost	388,249	388,795	16
17	Accumulated Depreciation (book methods)	(891,666)	(866,023)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	29,743	29,743	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,093,196	\$ 1,094,304	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,810,118	\$ 1,811,226	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 736,261	\$ 736,261	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,844	69,844	30
31	Accrued Taxes Payable (excluding real estate taxes)	66,982	66,982	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,568	23,568	32
33	Accrued Interest Payable	5,727	5,727	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	14,083	14,083	36
37	<u>Accrued Management Fees</u>	192,852	192,852	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,109,317	\$ 1,109,317	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,463,753	1,463,753	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,463,753	\$ 1,463,753	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,573,070	\$ 2,573,070	46
47	TOTAL EQUITY(page 18, line 24)	\$ (762,952)	\$ (761,844)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,810,118	\$ 1,811,226	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,337	1
2	Restatements (describe):		2
3	Prior Period Adjustment Made After Cost Reports Were Filed	(1,007,924)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (992,587)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	229,635	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)	\$ 229,635	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)	\$ (762,952)	24 *

* 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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 2,681,528	1	
2	Discounts and Allowances for all Levels	(263,409)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,418,119	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	386,350	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 386,350	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	3,687	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	103,204	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	8,840	20	
21	Other Medical Services	2,270	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 118,001	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	608	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 608	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Jail Meals Revenue	24,105	28	
28a	Miscellaneous Income and Gain on Sale	207	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,312	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,947,390	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	636,595	31	
32	Health Care	1,182,698	32	
33	General Administration	440,948	33	
B. Capital Expense				
34	Ownership	145,981	34	
C. Ancillary Expense				
35	Special Cost Centers	176,660	35	
36	Provider Participation Fee	134,873	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,717,755	40	
41	Income before Income Taxes (line 30 minus line 40)**	229,635	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 229,635	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,732,253	44
45	Private Pay - Net Inpatient Revenue	368,875	45
46	Medicare - Net Inpatient Revenue	301,103	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	17,507	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(1,619)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,418,119	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	1,789	1,869	\$ 59,374	\$ 31.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,647	1,712	42,442	24.79	3
4	Licensed Practical Nurses	13,965	14,381	312,637	21.74	4
5	CNAs & Orderlies	29,843	30,731	336,625	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	1,928	22,872	11.86	9
10	Activity Assistants	314	314	2,852	9.08	10
11	Social Service Workers	1,415	1,463	17,997	12.30	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,158	15.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,535	11,733	105,418	8.98	15
16	Dishwashers					16
17	Maintenance Workers	1,811	1,983	27,044	13.64	17
18	Housekeepers	10,788	11,013	105,661	9.59	18
19	Laundry					19
20	Administrator	2,185	2,185	55,753	25.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,924	1,973	28,185	14.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,194	2,330	52,022	22.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Restorative Aides</u>	84	84	754	8.98	33
34	TOTAL (lines 1 - 33)	83,446	85,779	\$ 1,201,794 *	\$ 14.01	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	19	\$ 1,048	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,000	L10, C3	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)	19	\$ 17,048		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	324	\$ 10,260	L10, C3	50
51	Licensed Practical Nurses	28	1,093	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	352	\$ 11,353		53

Facility Name & ID Number Eastview Terrace

Report Period Beginning: 1/1/2015

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	
Lacy Mossman	Administrator	0	\$ 35,432	Workers' Compensation Insurance	\$ 36,991	IDPH License Fee	\$ 2,584	
Lenda Johnson	Administrator	0	20,321	Unemployment Compensation Insurance	36,919	Advertising: Employee Recruitment	912	
				FICA Taxes	85,377	Health Care Worker Background Check		
				Employee Health Insurance	(13,557)	(Indicate # of checks performed 78)	711	
				Employee Meals		Miscellaneous Licenses & Permits	275	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	318	
				Employee Relations	1,017	Home Office Allocation	732	
				Employee Retirement	748			
				Home Office Allocation	26,856			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,753	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,214		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(318)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 207,500				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 207,500				TOTAL (agree to Sch. V, line 20, col. 8)	
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
Honkamp Krueger & Co.	Accounting Fees		\$ 1,910				Out-of-State Travel	\$
Mediacom	Computer Services		1,631					
E-Health Data Solutions	Computer Services		4,902				In-State Travel	
Allscripts	Computer Services		1,213	N/A				
							Seminar Expense	
							Home Office Allocation	63
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 9,656	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 63	

* Attach copy of IMRF notifications

**See instructions.

Eastview Terrace
0053009
Period Beginning
Period End

1/1/2015
12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,656
Home Office Allocation		
Denton's US LLP	Legal	90
Applegate and Thorne	Legal	14
Miller Hall and Triggs	Legal	14
Healthcare Resources International	Legal	74
Lexis Nexis	Legal	5
GoffWilson	Legal	614
Private Bank	Legal	205
CliftonLarson Allen	Accountants	1,867
Ginoli & Co.	Accountants	3,212
Private Bank	Accountants	1,012
Miscellaneous	Computer Services	43
CCH	Computer Services	11
PTC Select	Computer Services	15
Advanced Answers on Demand	Computer Services	1965
Stratus Networks	Computer Services	357
Kemper Technology	Computer Services	526
AT&T	Computer Services	5
Ability Network	Computer Services	506
CIAN	Computer Services	356
Comcast	Computer Services	13
Emdeon	Computer Services	29
Charter Communications	Computer Services	24
Allscripts	Computer Services	18
Allpayer Exchange	Computer Services	11
E-Health Technologies	Computer Services	8

Macquarie Technology Services	Computer Services	12
Optimizer	Other Prof Fees	34
D.J. Howard Appraisers	Other Prof Fees	31
Key Corporate Services	Other Prof Fees	104
Consolidated Land Surveying	Other Prof Fees	66
Alan Litwiller	Other Prof Fees	14

Total (agree to Schedule V, line 19, column 8)		<u>20,911</u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Eastview Terrace

0053009

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,485 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,873
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. \$ 3,687
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.