

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0046037</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Palm Terrace of Mattoon</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1000 Palm Avenue</u> <u>Mattoon</u> <u>61938</u>																									
Number City Zip Code																									
County: <u>Coles</u>																									
Telephone Number: <u>(217) 234-7403</u> Fax # <u>(217) 258-6642</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>11/1/2002</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Palm Terrace of Mattoon# 0046037 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 bedsN/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>178</u>	Skilled (SNF)	<u>178</u>	<u>64,970</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>178</u>	TOTALS	<u>178</u>	<u>64,970</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>40,990</u>	<u>6,294</u>	<u>4,674</u>	<u>51,958</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>40,990</u>	<u>6,294</u>	<u>4,674</u>	<u>51,958</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.97%

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?

YesG. 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 11/1/2002

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

YES

☒Date 11/1/2002

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

178

and days of care provided

3,880Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	217,428	35,450	5,221	258,099		258,099	9,459	267,558		1
2	Food Purchase		334,569		334,569		334,569	(8,261)	326,308		2
3	Housekeeping	214,124	53,060		267,184		267,184	73	267,257		3
4	Laundry	81,324	25,183		106,507		106,507	13	106,520		4
5	Heat and Other Utilities			185,840	185,840		185,840	746	186,586		5
6	Maintenance	52,260	26,120	25,999	104,379		104,379	6,352	110,731		6
7	Other (specify):* Home Off. Ben. All.							1,260	1,260		7
8	TOTAL General Services	565,136	474,382	217,060	1,256,578		1,256,578	9,642	1,266,220		8
	B. Health Care and Programs										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	2,246,029	143,135	13,607	2,402,771		2,402,771	91	2,402,862		10
10a	Therapy			571,736	571,736		571,736		571,736		10a
11	Activities	45,835	20	(197)	45,658		45,658	(25,006)	20,652		11
12	Social Services	107,554	39		107,593		107,593		107,593		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	2,399,418	143,194	623,546	3,166,158		3,166,158	(24,915)	3,141,243		16
	C. General Administration										
17	Administrative	32,041		467,800	499,841		499,841	(390,450)	109,391		17
18	Directors Fees										18
19	Professional Services			37,338	37,338		37,338	59,575	96,913		19
20	Dues, Fees, Subscriptions & Promotions			7,931	7,931		7,931	(78)	7,853		20
21	Clerical & General Office Expenses	27,673	8,570	19,883	56,126		56,126	113,040	169,166		21
22	Employee Benefits & Payroll Taxes			386,807	386,807		386,807	4,395	391,202		22
23	Inservice Training & Education							274	274		23
24	Travel and Seminar							18	18		24
25	Other Admin. Staff Transportation			24,664	24,664		24,664	13,059	37,723		25
26	Insurance-Prop.Liab.Malpractice			56,544	56,544		56,544	2,022	58,566		26
27	Other (specify):* Home Off. Ben. All.							25,258	25,258		27
28	TOTAL General Administration	59,714	8,570	1,000,967	1,069,251		1,069,251	(172,887)	896,364		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,024,268	626,146	1,841,573	5,491,987		5,491,987	(188,160)	5,303,827		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			79,838	79,838		79,838	42,518	122,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			202,822	202,822		202,822	54,755	257,577			32
33	Real Estate Taxes			39,272	39,272		39,272	1,338	40,610			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,776	28,776		28,776	1,492	30,268			35
36	Other (specify):*											36
37	TOTAL Ownership			350,708	350,708		350,708	100,103	450,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,336		177,336		177,336		177,336			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			575,558	575,558		575,558		575,558			42
43	Other (specify):* Non-allowable Costs	31,247	(129)	94,280	125,398		125,398	(125,398)				43
44	TOTAL Special Cost Centers	31,247	177,207	669,838	878,292		878,292	(125,398)	752,894			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,055,515	803,353	2,862,119	6,720,987		6,720,987	(213,455)	6,507,532			45

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

		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	(8,580)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,096)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,028	30		9
10	Interest and Other Investment Income	(1,777)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(531)	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	(27,961)	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	(22,296)	43		24
25	Fund Raising, Advertising and Promotional	(36,482)	43		25
	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	(50,751)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,446)		\$	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 Amount	2 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)	(55,009)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (55,009)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (213,455)		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 Yes	2 No	3 Amount	4 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

Palm Terrace of Mattoon

Report Period Beginning: ID# 0046037
Ending: 1/1/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (11,737)	43	1
2	X-Rays-Part A	(10,798)	43	2
3	Offset Transportation Revenue	(25,006)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(861)	21	4
5	Offset Chamber of Commerce Dues	(852)	20	5
6	Resident Flowers	(81)	43	6
7	Disallowed Special Events	2	43	7
8	Pet Expense	(1,418)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50,751)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Palm Terrace of Mattoon # 0046037 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	9,459	0	0	0	0	0	0	0	0	0	9,459	1
2	Food Purchase	(8,580)	319	0	0	0	0	0	0	0	0	0	(8,261)	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	13	0	0	0	0	0	0	0	0	0	13	4
5	Heat and Other Utilities	0	746	0	0	0	0	0	0	0	0	0	746	5
6	Maintenance	0	5,247	0	1,105	0	0	0	0	0	0	0	6,352	6
7	Other (specify):*	0	1,260	0	0	0	0	0	0	0	0	0	1,260	7
8	TOTAL General Services	(8,580)	17,117	0	1,105	0	0	0	0	0	0	0	9,642	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	91	0	0	0	0	0	0	0	0	0	91	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(25,006)	0	0	0	0	0	0	0	0	0	0	(25,006)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(25,006)	91	0	0	0	0	0	0	0	0	0	(24,915)	16
	C. General Administration													
17	Administrative	0	(390,450)	0	0	0	0	0	0	0	0	0	(390,450)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	51,093	0	8,482	0	0	0	0	0	0	0	59,575	19
20	Fees, Subscriptions & Promotions	(852)	0	728	46	0	0	0	0	0	0	0	(78)	20
21	Clerical & General Office Expenses	(861)	0	107,067	6,834	0	0	0	0	0	0	0	113,040	21
22	Employee Benefits & Payroll Taxes	0	0	0	4,395	0	0	0	0	0	0	0	4,395	22
23	Inservice Training & Education	0	0	179	95	0	0	0	0	0	0	0	274	23
24	Travel and Seminar	0	0	18	0	0	0	0	0	0	0	0	18	24
25	Other Admin. Staff Transportation	0	0	12,268	791	0	0	0	0	0	0	0	13,059	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,022	0	0	0	0	0	0	0	0	2,022	26
27	Other (specify):*	0	0	25,258	0	0	0	0	0	0	0	0	25,258	27
28	TOTAL General Administration	(1,713)	(339,357)	147,540	20,643	0	0	0	0	0	0	0	(172,887)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(35,299)	(322,149)	147,540	21,748	0	0	0	0	0	0	0	(188,160)	29

Summary B

12/31/2012

[illegible]

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 9,459	\$ 9,459	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	319	319	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	73	73	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	13	13	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	746	746	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	5,247	5,247	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,260	1,260	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	91	91	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	467,800	Petersen Health Care, Inc.	100.00%	77,350	(390,450)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	51,093	51,093	12
13	V								13
14	Total			\$ 467,800			\$ 145,651	\$ * (322,149)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 728	\$ 728	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	107,067	107,067	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	179	179	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	18	18	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	12,268	12,268	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	2,022	2,022	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	25,258	25,258	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	9,088	9,088	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	18,069	18,069	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,338	1,338	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,332	1,332	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		\$			\$ 177,367	\$ * 177,367	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 II, Inc.	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	1,105	1,105	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12	Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	8,482	8,482	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	46	46	26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	6,834	6,834	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	4,395	4,395	28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	95	95	29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	791	791	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	29,402	29,402	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	38,463	38,463	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	160	160	38
39	Total			\$			\$ 89,773	\$ * 89,773	39

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

Facility Name & ID Number

Palm Terrace of Mattoon

0046037

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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 I	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 Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	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 I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	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	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				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

Palm Terrace of Mattoon

0046037

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Palm Terrace of Mattoon

0046037

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				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 Palm Terrace of Mattoon # 0046037 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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											3
4	N/A										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 Palm Terrace of Mattoon # 0046037 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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	1,569,393	74	\$ 285,707	\$ 284,214	51,958	\$ 9,459	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	51,958	319	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	51,958	73	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	51,958	13	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	51,958	746	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	51,958	5,247	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	51,958	1,260	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	51,958	91	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	51,958	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	51,958	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	51,958	77,350	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	51,958	51,093	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	51,958	728	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	51,958	107,067	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	51,958	179	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	51,958	18	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	51,958	12,268	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	51,958	2,022	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	51,958	25,258	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	51,958	9,088	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	51,958	18,069	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	51,958	1,338	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	51,958	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	51,958	1,332	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 323,018	25

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

1/1/2012

Ending:

2/31/2012

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 ☐

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

Name of Related Organization

Petersen Health Care II, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	336,407	13	\$	\$	51,958	\$	1
2	2	Food	Resident Days	336,407	13			51,958		2
3	3	Housekeeping	Resident Days	336,407	13			51,958		3
4	4	Laundry	Resident Days	336,407	13			51,958		4
5	5	Utilities	Resident Days	336,407	13			51,958		5
6	6	Maintenance	Resident Days	336,407	13	7,156		51,958	1,105	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,407	13			51,958		7
8	10	Nursing and Medical Records	Resident Days	336,407	13			51,958		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,407	13			51,958		9
10	17	Administrative	Resident Days	336,407	13			51,958		10
11	19	Professional Services	Resident Days	336,407	13	54,918		51,958	8,482	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,407	13	300		51,958	46	12
13	21	Clerical and General Office	Resident Days	336,407	13	44,246		51,958	6,834	13
14	22	Employee Benefits & Payroll	Resident Days	336,407	13	28,459		51,958	4,395	14
15	23	Inservice Training & Education	Resident Days	336,407	13	617		51,958	95	15
16	24	Travel and Seminar	Resident Days	336,407	13			51,958		16
17	25	Other Admin. Staff Transport.	Resident Days	336,407	13	5,121		51,958	791	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,407	13			51,958		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,407	13			51,958		19
20	30	Depreciation	Resident Days	336,407	13	190,366		51,958	29,402	20
21	32	Interest	Resident Days	336,407	13	249,037		51,958	38,463	21
22	33	Real Estate Taxes	Resident Days	336,407	13			51,958		22
23	34	Rent-Facility and Grounds	Resident Days	336,407	13			51,958		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,407	13	1,038		51,958	160	24
25	TOTALS					\$ 581,258	\$		\$ 89,773	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		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	First Merit		X	Mortgage	Varies	2/1/12	\$ 3,544,700	\$ 3,467,086	1/31/17	Varies	\$ 202,689	1	
2	Better Banks		X	Vehicle	\$383.00	7/16/10	8,555	Paid	7/16/12	0.0699	133	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$383.00		\$ 3,553,255	\$ 3,467,086			\$ 202,822	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(1,777)	11	
12								Home Office Allocation-PHC			18,069	12	
13								Home Office Allocation-PHC II			38,463	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 54,755	14	
15	TOTALS (line 9+line14)						\$ 3,553,255	\$ 3,467,086			\$ 257,577	15	

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

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 2011 report.			\$	40,500	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.)		2011	\$	39,510	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(990)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	40,262	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.)			\$	1,338	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	40,610	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	38,264	8	
		2008	39,497	9	
		2009	39,261	10	
		2010	39,293	11	
		2011	39,510	12	
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- 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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Palm Terrace of Mattoon

COUNTY
Coles

FACILITY IDPH LICENSE NUMBER
0046037

CONTACT PERSON REGARDING THIS REPORT
Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-1-00908-000	Long-Term Care Facility	\$ 39,509.50	\$ 39,509.50
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 39,509.50	\$ 39,509.50

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,000 B. General Construction Type: Exterior Brick & 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>44,000</u>	<u>2002</u>	<u>\$ 32,860</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	44,000		\$ 32,860	3

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	178		2002	1969	\$ 528,492	\$	39	\$ 13,551	\$ 13,551	\$ 133,252	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alzheimer's unit renovation			2003	4,026		15	268	268	2,435	9
10	Alzheimer's unit renovation			2003	26,810		15	1,787	1,787	16,233	10
11	Roof			2004	7,814		35	223	223	1,803	11
12	Boiler			2004	4,019		35	115	115	920	12
13	Alzheimer's wing renovation per cap proj			2005	312,682		30	10,423	10,423	78,172	13
14	New roof			2005	36,428		30	1,214	1,214	8,802	14
15	New flooring			2005	27,858		10	2,786	2,786	19,734	15
16	Windows			2006	3,375		25	135	135	878	16
17	Sidewalks			2006	2,980		15	199	199	1,293	17
18	Asphalt			2006	43,960		15	2,931	2,931	19,051	18
19	Sidewalks			2006	6,300		15	420	420	2,730	19
20	86 - Smoke			2006	7,545		7	1,078	1,078	7,007	20
21	Roof			2006	68,274		25	2,731	2,731	17,751	21
22	Tile Flooring			2006	1,648		25	66	66	429	22
23	New roof			2006	3,145		30	105	105	682	23
24	Alzheimer's wing renovation- contractors application #6			2005	39,645		30	1,322	1,322	9,915	24
25	Alzheimer's wing renovation - arch. Fees			2005	1,157		30	39	39	292	25
26	Alzheimer's wing renovation- contractors application #7			2005	4,252		30	142	142	1,065	26
27	Alzheimer's wing - doors and hardware			2005	1,063		30	35	35	263	27
28	Alzheimer's wing renovation- fire system			2005	1,485		30	50	50	375	28
29	Sidewalks			2007	9,988		15	666	666	3,663	29
30	Road Work			2007	3,803		15	254	254	1,397	30
31	Blinds			2007	2,556		10	256	256	1,408	31
32	Rooftop A/C Unit			2007	5,123		10	512	512	2,816	32
33	Fire Alarm			2007	5,244		10	524	524	2,882	33
34	New roof			2007	40,644		30	1,354	1,354	7,447	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Heater	2008	\$ 4,623	\$	5	\$ 924	\$ 924	\$ 4,158	37
38	Garage Door	2008	3,270		10	328	328	1,476	38
39	Water Heater	2008	4,823		5	964	964	4,338	39
40	A/C Unit-Rooftop Middle	2009	7,317		15	488	488	1,708	40
41	A/C Unit-Annex West	2009	7,245		15	484	484	1,694	41
42	Roof	2009	153,225		25	6,130	6,130	21,455	42
43	Garage	2009	20,375		20	1,019	1,019	3,591	43
44	Sidewalk Repair	2010	2,528		7	362	362	905	44
45	Sidewalk Repair	2011	6,108		15	408	408	612	45
46	Kitchen Exhaust Fan	2011	12,461		10	1,246	1,246	1,869	46
47	Roof Replacement on South West Wing roof	2011	22,370		25	895	895	1,342	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	Land Improvements Booked			6,183			(6,183)		60
61	Building Booked			13,551			(13,551)		61
62	Building Improvement Booked			37,525			(37,525)		62
63									63
64	2012-Home Office Allocation-Building Improvements		24,300			583	583		64
65	2012-Home Office Allocation-Land Improvements		2,268			145	145		65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,471,229	\$ 57,259		\$ 57,162	\$ (97)	\$ 385,843	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	\$ 250,889	\$ 19,270	\$ 25,090	\$ 5,820	5-10 yrs.	\$ 184,199	71
72	Current Year Purchases	10,408	1,487	520	(967)	10 yrs.	520	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			37,762	37,762			74
75	TOTALS	\$ 261,297	\$ 20,757	\$ 63,372	\$ 42,615		\$ 184,719	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	Facility	2002 Jetta	2003	\$ 17,080	\$	\$	\$		\$ 17,080	76
77	Facility	2003 Dodge Truck	2003	20,300					20,300	77
78	Facility	1999 Ford	2010	9,112	1,822	1,822			4,555	78
79										79
80	TOTALS			\$ 46,492	\$ 1,822	\$ 1,822	\$		\$ 41,935	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,811,878 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,838 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,356 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,518 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 612,497 85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Nursing Area Remodel	\$ 116,975	92
93			93
94			94
95		\$ 116,975	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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: \$ 25,821
- 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	Facility	2012 Ford E250 Van	\$ 822.05	\$ 4,447	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 4,447	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. /2013 \$
13. /2014 \$
14. /2015 \$

* 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.

Palm Terrace of Mattoon
0046307
Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$	16,119
Dishwasher		1,041
Laundry Equipment		-
Copier		7,169
Home Office Allocation		<u>1,492</u>
		<u><u>25,821</u></u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)										
		1	2	3	4	5	6	7	8	
	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	\$	12,456	\$ 186,841	\$	12,456	\$ 186,841	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		8,068	121,021		8,068	121,021	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		17,577	263,654		17,577	263,654	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				177,336		177,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			15	220		15	220	13
14	TOTAL			\$	38,116	\$ 571,736	\$ 177,336	38,116	\$ 749,072	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,634,838	\$ 7,634,838	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 62,000)	1,401,928	1,401,928	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,732	57,732	6
7	Other Prepaid Expenses	26,521	26,521	7
8	Accounts Receivable (Employee Loans)	17,656	17,656	8
9	Other(specify): Security Deposits & PPD Leases	12,360	12,360	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,151,035	\$ 9,151,035	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	112,553	32,860	13
14	Buildings, at Historical Cost	528,492	552,792	14
15	Leasehold Improvements, at Historical Cost	833,330	918,437	15
16	Equipment, at Historical Cost	307,789	307,789	16
17	Accumulated Depreciation (book methods)	(657,415)	(612,497)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Cons. In Progress	105,388	105,388	22
23	Other(specify): Intercompany Loans	251,000	251,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,481,137	\$ 1,555,769	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,632,172	\$ 10,706,804	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,270,651	\$ 1,270,651	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,803	174,803	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,642	33,642	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,262	40,262	32
33	Accrued Interest Payable	17,335	17,335	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	85,249	85,249	36
37	Accrued Management Fees	153,628	153,628	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,775,570	\$ 1,775,570	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,467,086	3,467,086	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Due From Intercompany	2,155	2,155	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,469,241	\$ 3,469,241	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,244,811	\$ 5,244,811	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,387,361	\$ 5,461,993	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,632,172	\$ 10,706,804	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,151,146	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,151,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	236,216	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)	\$ 236,216	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)	\$ 5,387,361	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 6,180,497	1	
2 Discounts and Allowances for all Levels	(459,866)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,720,631	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	908,663	6	
7 Oxygen	573	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 909,236	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	8,580	14	
15 Telephone, Television and Radio	650	15	
16 Rental of Facility Space		16	
17 Sale of Drugs	263,727	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray	21,352	20	
21 Other Medical Services	5,383	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 299,692	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	1,777	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,777	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous Revenue	861	28	
28a Transportation Revenue	25,006	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,867	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,957,203	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,256,578	31	
32 Health Care	3,166,158	32	
33 General Administration	1,069,251	33	
B. Capital Expense			
34 Ownership	350,708	34	
C. Ancillary Expense			
35 Special Cost Centers	302,734	35	
36 Provider Participation Fee	575,558	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,720,987	40	
41 Income before Income Taxes (line 30 minus line 40)**	236,216	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 236,216	43	

	1		2
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 4,111,280	44	
45 Private Pay - Net Inpatient Revenue	791,555	45	
46 Medicare - Net Inpatient Revenue	760,369	46	
47 Other-(specify) <u>Veterans Inpatient Revenue</u>	62,760	47	
48 Other-(specify) <u>Charity and Insurance Contracutal Allowance</u>	(5,333)	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,720,631	49	

* 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.

*** 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 72,241	\$ 34.73	1
2	Assistant Director of Nursing	4,190	4,190	94,635	22.59	2
3	Registered Nurses	12,114	13,070	302,781	23.17	3
4	Licensed Practical Nurses	23,691	25,620	481,377	18.79	4
5	CNAs & Orderlies	96,341	102,122	1,137,568	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	1,972	22,184	11.25	9
10	Activity Assistants					10
11	Social Service Workers	7,647	7,819	107,554	13.76	11
12	Dietician					12
13	Food Service Supervisor	3,913	4,129	65,581	15.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,595	17,198	151,847	8.83	15
16	Dishwashers					16
17	Maintenance Workers	3,816	3,922	52,260	13.32	17
18	Housekeepers	24,132	24,940	214,124	8.59	18
19	Laundry	8,626	9,154	81,324	8.88	19
20	Administrator	2,080	2,080	77,350	37.19	20
21	Assistant Administrator	2,080	2,080	32,041	15.40	21
22	Other Administrative					22
23	Office Manager	1,940	2,011	27,673	13.76	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	1,807	1,935	24,469	12.65	31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	10,751	11,535	187,856	16.29	33
34	TOTAL (lines 1 - 33)	223,611	235,857	\$ 3,132,865 *	\$ 13.28	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	104	\$ 5,221	L1, C3	35
36	Medical Director	Monthly	38,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,273	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) Psychologist		(175)		46
47	Dentist		(25)		47
48					48
49	TOTAL (lines 35 - 48)	104	\$ 53,694		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	77	\$ 2,255	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	77	\$ 2,255		53

Palm Terrace of Mattoon
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Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,768	4,086	82,844	20.28
Restorative Aide	981	1,141	12,487	10.94
Alzheimer's Coordinator	1,916	1,989	37,627	18.92
Transportation	2,045	2,102	23,651	11.25
Marketing	2,041	2,217	31,247	14.09
TOTAL	10,751	11,535	187,856	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Glenna Birch	Administrator	0	\$ 77,350
Jamie Wilson	Asst. Administrator	0	32,041
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 109,391
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 467,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 467,800
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 1,753
Mediacom	Computer Services		300
Honkamp Krueger & Co.	Accounting Services		2,528
Allscripts	Computer Services		1,200
Tazewell Co. Sheriff's Office	Legal Fees		44
Brown & James	Legal Services		706
Tazewell Co. Circuit Clerk	Legal Fees		219
Coles County Circuit Clerk	Legal Fees		84
Sorling Northrup	Legal Fees		504
Estate of David Delaney	Legal Settlement		30,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 37,338
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 69,548
Unemployment Compensation Insurance			63,670
FICA Taxes			239,703
Employee Health Insurance			12,658
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			500
Employee Retirement			728
Home Office Allocation			4,395
TOTAL (agree to Schedule V, line 22, col.8)			\$ 391,202
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 3,980
Advertising: Employee Recruitment			203
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks	206		2,061
Miscellaneous Licenses & Permits			835
Miscellaneous Dues & Subscriptions			852
Home Office Allocation			774
Less: Public Relations Expense			(852)
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,853
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			18
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 18

*** Attach copy of IMRF notifications**

****See instructions.**

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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		37,338
Home Office Allocation		
Sorling Northrup	Legal	162
Ginoli & Company	Accountants	3,631
Miscellaneous	Computer Services	140
Nebo Systems	Computer Services	4
Advanced Answers on Demand	Computer Services	7,895
Access 2 Go	Computer Services	332
Stratus Networks	Computer Services	327
Kemper Technology	Computer Services	539
CCH	Computer Services	28
Medifax	Computer Services	63
Vision Share/Ability Network	Computer Services	602
Barracuda	Computer Services	21
CIAN	Computer Services	164
Comcast	Computer Services	51
Postini	Computer Services	510
Optimizer Systems	Other Prof Fees	80
Marotta Gund Budd & Dzera	Other Prof Fees	36,559
David Budde	Other Prof Fees	31
Courtney Bourban	Other Prof Fees	450
All Scripts	Other Prof Fees	1,963
Heritage Enterprises	Other Prof Fees	32
Miscellaneous Vendors	Other Prof Fees	76
Katten Muchin Rosenman	Legal	2,000
U.S. Bank	Accountants	2,550
Medifax-EDI	Computer Services	197

Polaris Group	Other Prof Fees	792
Healthlink	Other Prof Fees	376

Total (agree to Schedule V, line 19, column 8)	<u>96,913</u>
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Palm Terrace of Mattoon
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Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
Vendor/Payee	Invoice Total	Allocation %	Total
Tazewell County Sheriff's Office	44.50	100%	45
Tazewell County Circuit Clerk	219.00	100%	219
Estate of David Delaney	30,000.00	100%	30,000
Sorling Northrup	126.00	100%	126
Brown and James	27.84	100%	28
Sorling Northrup	105.00	100%	105
Sorling Northrup	105.00	100%	105
Brown and James	677.62	100%	678
Coles County Circuit Clerk	84.00	100%	84
Sorling Northrup	63.00	100%	63
Sorling Northrup	105.00	100%	105
Home Office Allocation			
Sorling Northrup	5,053.00	3.20%	162
Katten Muchin Rosenman	12,947.00	15.45%	2,000
Total Legal Fees			<u>33,719</u>

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. _____
- (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. \$ 28,973 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 575,558
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. \$ 8,580
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 25,006
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? 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.