

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0052274</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>1/1/2020</u> to <u>12/31/2020</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 Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</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 Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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	(Type or Print Name) <u>Mark Petersen</u>																								
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	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(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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	☒ Limited Liability Co.	_____																							
	☐ 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

#

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

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	178	Skilled (SNF)	178	64,970	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	178	TOTALS	178	64,970	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	32,557	3,775	2,109	38,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,557	3,775	2,109	38,441	14

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

59.17%

D. How many bed reserve days during this year were paid by the Department?

None

(Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

X

NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

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

X

Date

11/1/2002

NO

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

YES

X

NO

If YES, enter number of beds certified

178

and days of care provided

2,035

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2020

Fiscal Year:

12/31/2020

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

Facility Name & ID Number **Palm Terrace of Mattoon** # **0052274** Report Period Beginning: **1/1/2020** Ending: **12/31/2020**
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	245,486	47,084	917	293,487		293,487	10,235	303,722			1
2	Food Purchase		313,399		313,399		313,399	(3,737)	309,662			2
3	Housekeeping	157,253	62,616		219,869		219,869	198	220,067			3
4	Laundry	41,777	18,159		59,936		59,936		59,936			4
5	Heat and Other Utilities			160,756	160,756		160,756	699	161,455			5
6	Maintenance	97,859	30,452	30,601	158,912		158,912	7,675	166,587			6
7	Other (specify):*											7
8	TOTAL General Services	542,375	471,710	192,274	1,206,359		1,206,359	15,070	1,221,429			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,959,679	140,511	221,385	2,321,575		2,321,575	8,371	2,329,946			10
10a	Therapy			343,664	343,664		343,664		343,664			10a
11	Activities	91,094	102	325	91,521		91,521	(1,689)	89,832			11
12	Social Services	67,157			67,157		67,157		67,157			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,117,930	140,613	595,374	2,853,917		2,853,917	6,682	2,860,599			16
	C. General Administration											
17	Administrative	77,004		317,500	394,504		394,504	(260,576)	133,928			17
18	Directors Fees											18
19	Professional Services			12,949	12,949		12,949	91,258	104,207			19
20	Dues, Fees, Subscriptions & Promotions			4,840	4,840		4,840	5,240	10,080			20
21	Clerical & General Office Expenses	93,167	5,184	27,592	125,943		125,943	63,443	189,386			21
22	Employee Benefits & Payroll Taxes			312,469	312,469		312,469	17,422	329,891			22
23	Inservice Training & Education			42	42		42	105	147			23
24	Travel and Seminar							33	33			24
25	Other Admin. Staff Transportation			5,236	5,236		5,236	7,333	12,569			25
26	Insurance-Prop.Liab.Malpractice			57,082	57,082		57,082	56,942	114,024			26
27	Other (specify):*											27
28	TOTAL General Administration	170,171	5,184	737,710	913,065		913,065	(18,800)	894,265			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,830,476	617,507	1,525,358	4,973,341		4,973,341	2,952	4,976,293			29

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

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

Facility Name & ID Number Palm Terrace of Mattoon #0052274 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			19,839	19,839		19,839	96,143	115,982			30
31	Amortization of Pre-Op. & Org.							7,026	7,026			31
32	Interest			615	615		615	109,757	110,372			32
33	Real Estate Taxes							62,376	62,376			33
34	Rent-Facility & Grounds			385,117	385,117		385,117	(385,117)				34
35	Rent-Equipment & Vehicles			9,505	9,505		9,505	200,851	210,356			35
36	Other (specify):*											36
37	TOTAL Ownership			415,076	415,076		415,076	91,036	506,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,915		36,915		36,915		36,915			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			317,455	317,455		317,455		317,455			42
43	Other (specify):*		618	126,506	127,124		127,124	(127,124)				43
44	TOTAL Special Cost Centers		37,533	443,961	481,494		481,494	(127,124)	354,370			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,830,476	655,040	2,384,395	5,869,911		5,869,911	(33,136)	5,836,775			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,737)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,298)	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	(4,365)	30		9
10	Interest and Other Investment Income	(137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(298)	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	(46,966)	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	(39,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,527)	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	(33,298)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,626)		\$	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)	112,490	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 112,490		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (33,136)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (19,144)	43	1
2	X-Rays-Part A	(4,323)	43	2
3	Offset Transportation Revenue	(1,689)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(23)	21	4
5	Pet Expense	(414)	43	5
6	Offset Nursing Supplies Revenue	(6,726)	10	6
7	Disallowed Special Event	(979)	43	7
8				8
9				9
10				10
11				11
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(33,298)		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 Management, Inc.	100.00%	\$ 10,235	\$ 10,235	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	198	198	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	699	699	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	6,147	6,147	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	9,591	9,591	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	317,500	Petersen Health Care Management, Inc.	100.00%	56,924	(260,576)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	33,623	33,623	12
13	V								13
14	Total			\$ 317,500			\$ 117,417	\$ * (200,083)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,240	\$ 5,240	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	63,466	63,466	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,422	17,422	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	105	105	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	33	33	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	7,333	7,333	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,118	1,118	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	10,361	10,361	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	505	505	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	403	403	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	3,716	3,716	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			\$			\$ 109,702	\$ * 109,702	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Management Company, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Management Company, LLC	100.00%	5,506	5,506	22
23	V	15 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Management Company, LLC	100.00%	50,935	50,935	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Management Company, LLC	100.00%	3,837	3,837	33
34	V	31 Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32 Interest		Petersen Management Company, LLC	100.00%	601	601	35
36	V	33 Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	197,135	197,135	38
39	Total		\$			\$ 258,014	\$ * 258,014	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	6	Maintenance	\$	Petersen 24, LLC	100.00%	\$ 1,528	\$ 1,528	15
16	V	19	Professional Services	\$	Petersen 24, LLC	100.00%	6,700	6,700	16
17	V	21	Equipment		Petersen 24, LLC	100.00%			17
18	V	26	Insurance-Property		Petersen 24, LLC	100.00%	7,535	7,535	18
19	V	26	Insurance-Liability		Petersen 24, LLC	100.00%	24,151	24,151	19
20	V	26	Insurance-Mortgage Insurance		Petersen 24, LLC	100.00%	24,138	24,138	20
21	V	30	Depreciation		Petersen 24, LLC	100.00%	86,310	86,310	21
22	V	31	Amortization		Petersen 24, LLC	100.00%	7,026	7,026	22
23	V	32	Interest	1,654	Petersen 24, LLC	100.00%	110,442	108,788	23
24	V	33	Real Estate Taxes		Petersen 24, LLC	100.00%	61,973	61,973	24
25	V	34	Rent-Income and Grounds	385,117	Petersen 24, LLC	100.00%		(385,117)	25
26	V	43	Service Charges		Petersen 24, LLC	100.00%	1,825	1,825	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			\$ 386,771			\$ 331,628	\$ * (55,143)	39

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

Facility Name & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

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			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				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 # 0052274 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Palm Terrace of Mattoon# 0052274

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 341,562	\$ 398,718	38,441	\$ 10,235	1
2	2	Food	Resident Days	75	0	0	38,441	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	38,441	198	3
4	5	Utilities	Resident Days	75	23,320	0	38,441	699	4
5	6	Maintenance	Resident Days	75	205,132	187,746	38,441	6,147	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	38,441	0	6
7	9	Medical Director	Resident Days	75	0	0	38,441	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	38,441	9,591	8
9	10A	Therapy	Resident Days	75	0	0	38,441	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	38,441	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	38,441	56,924	11
12	19	Professional Services	Resident Days	75	1,122,028	0	38,441	33,623	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	38,441	5,240	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	38,441	63,466	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	38,441	17,422	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	38,441	105	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	38,441	33	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	38,441	7,333	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	38,441	1,118	19
20	30	Depreciation	Resident Days	75	345,756	0	38,441	10,361	20
21	31	Amortization	Resident Days	75	0	0	38,441	0	21
22	32	Interest	Resident Days	75	16,842	0	38,441	505	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	38,441	403	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	38,441	3,716	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 227,119	25

Facility Name & ID Number Palm Terrace of Mattoon# 0052274

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 Management Company, LLC

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	130,685	6	\$	\$	38,441	\$	1
2	2	Food	Resident Days	130,685	6			38,441		2
3	3	Housekeeping	Resident Days	130,685	6			38,441		3
4	4	Laundry	Resident Days	130,685	6			38,441		4
5	5	Utilities	Resident Days	130,685	6			38,441		5
6	6	Maintenance	Resident Days	130,685	6			38,441		6
7	7	Mgmt. Allocation of Benefits	Resident Days	130,685	6			38,441		7
8	10	Nursing and Medical Records	Resident Days	130,685	6	18,718		38,441	5,506	8
9	15	Mgmt. Allocation of Benefits	Resident Days	130,685	6			38,441		9
10	17	Administrative	Resident Days	130,685	6			38,441		10
11	19	Professional Services	Resident Days	130,685	6	173,161		38,441	50,935	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	130,685	6			38,441		12
13	21	Clerical and General Office	Resident Days	130,685	6			38,441		13
14	22	Employee Benefits & Payroll	Resident Days	130,685	6			38,441		14
15	23	Inservice Training & Education	Resident Days	130,685	6			38,441		15
16	24	Travel and Seminar	Resident Days	130,685	6			38,441		16
17	25	Other Admin. Staff Transport.	Resident Days	130,685	6			38,441		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	130,685	6			38,441		18
19	30	Depreciation	Resident Days	130,685	6	13,046		38,441	3,837	19
20	31	Amortization	Resident Days	130,685	6			38,441		20
21	32	Interest	Resident Days	130,685	6	2,043		38,441	601	21
22	33	Real Estate Taxes	Resident Days	130,685	6			38,441		22
23	34	Rent-Facility and Grounds	Resident Days	130,685	6			38,441		23
24	35	Rent-Equipment & Vehicles	Resident Days	130,685	6	670,184		38,441	197,135	24
25	TOTALS					\$ 877,152	\$		\$ 258,014	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	Huntington Bank		X	HUD Mortgage	Varies	5/1/13	4,673,000	\$ 3,640,868	4/30/38	Varies	\$ 110,442	1	
2	Dodge		X	Auto Loan	Vaies	6/29/20	39,027	36,055	6/28/25	Varies	615	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,712,027	\$ 3,676,923			\$ 111,057	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(1,791)	10	
11								Home Office Allocation-PHCM			505	11	
12								Home Office Allocation-PMC			601	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (685)	14	
15	TOTALS (line 9+line14)						\$ 4,712,027	\$ 3,676,923			\$ 110,372	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,138 Line # 26

* 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	130,827	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.)				\$	94,976	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(35,851)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	97,824	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		\$	403	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	62,376	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	43,413	8	FOR BHF USE ONLY	
		2016	123,987	9		
		2017	126,594	10		
		2018	127,009	11		
		2019	94,976	12		
Accrual based on prior year tax bill.				13	FROM R. E. TAX STATEMENT FOR 2019	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.

FACILITY NAME Palm Terrace of Mattoon COUNTY Coles
FACILITY IDPH LICENSE NUMBER 0052274
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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: 175,661

2. Number of Years Over Which it is Being Amortized: 25

3. Current Period Amortization: 7,026

4. Dates Incurred: May-December 2013

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	Facility	44,000	2002	\$ 32,860	1
2					2
3	TOTALS	44,000		\$ 32,860	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	178		2002	1969	\$ 528,492	\$	39	\$ 13,551	\$ 13,551	\$ 214,558
5										
6										
7										
8										
	Improvement Type**									
9	Alzheimer's unit renovation			2003	4,026		15			4,026
10	Alzheimer's unit renovation			2003	26,810		15			26,810
11	Roof			2004	7,814		35	223	223	3,587
12	Boiler			2004	4,019		35	115	115	1,840
13	Alzheimer's wing renovation per cap proj			2005	312,682		30	10,423	10,423	161,556
14	New roof			2005	36,428		30	1,214	1,214	18,514
15	New flooring			2005	27,858		10			27,858
16	Windows			2006	3,375		25	135	135	1,958
17	Sidewalks			2006	2,980		15	199	199	2,885
18	Asphalt			2006	43,960		15	2,931	2,931	42,499
19	Sidewalks			2006	6,300		15	420	420	6,090
20	86 - Smoke			2006	7,545		7			7,545
21	Roof			2006	68,274		25	2,731	2,731	39,599
22	Tile Flooring			2006	1,648		25	66	66	957
23	New roof			2006	3,145		30	105	105	1,522
24	Alzheimer's wing renovation- contractors application #6			2005	39,645		30	1,322	1,322	20,491
25	Alzheimer's wing renovation - arch. Fees			2005	1,157		30	39	39	604
26	Alzheimer's wing renovation- contractors application #7			2005	4,252		30	142	142	2,201
27	Alzheimer's wing - doors and hardware			2005	1,063		30	35	35	543
28	Alzheimer's wing renovation- fire system			2005	1,485		30	50	50	775
29	Sidewalks			2007	9,988		15	666	666	8,691
30	Road Work			2007	3,803		15	254	254	3,429
31	Blinds			2007	2,556		10			2,556
32	Rooftop A/C Unit			2007	5,123		10			5,123
33	Fire Alarm			2007	5,244		10			5,244
34	New roof			2007	40,644		30	1,354	1,354	18,279
35										
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 Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	2008	\$ 4,623	\$	5	\$	\$	\$ 4,623	37
38	Garage Door	2008	3,270		10			3,270	38
39	Water Heater	2008	4,823		5			4,823	39
40	A/C Unit-Rooftop Middle	2009	7,317		15	488	488	5,612	40
41	A/C Unit-Annex West	2009	7,245		15	484	484	5,566	41
42	Roof	2009	153,225		25	6,130	6,130	70,495	42
43	Garage	2009	20,375		20	1,019	1,019	11,743	43
44	Sidewalk Repair	2010	2,528		7			2,528	44
45	Sidewalk Repair	2011	6,108		15	408	408	3,876	45
46	Kitchen Exhaust Fan	2011	12,461		10	1,246	1,246	11,837	46
47	Roof Replacement on South West Wing roof	2011	22,370		25	895	895	8,502	47
48	Generator	2013	17,656		15	1,178	1,178	8,835	48
49	Sprinkler System Replacement	2013	184,250		25	7,370	7,370	55,275	49
50	Parking Lot Sealcoat	2013	6,105		7	437	437	6,105	50
51	Parking Lot Repair	2014	24,325		25	973	973	6,325	51
52	Vinyl Plank Floor in Main Hallways	2014	19,851		15	1,323	1,323	8,600	52
53	Nurse Call System Replacement	2015	19,567		7	2,796	2,796	15,378	53
54	Tiling for Activity Room, Office, Showers, Kitchen, Therapy Room	2015	204,104		15	13,608	13,608	74,844	54
55	Water Heater	2015	3,379		7	484	484	2,662	55
56	Water Heater	2016	3,785		7	540	540	2,430	56
57	Air Conditioner	2016	8,174		15	544	544	2,448	57
58	Furnace	2016	16,699		15	1,114	1,114	5,013	58
59	Furnance and Air Conditoner-Rooftop	2017	7,850		15	523	523	2,092	59
60	Condensing Unit	2019	4,798		15	320	320	480	60
61	Boiler	2019	4,453		7	636	636	954	61
62	Rooftop Heating and Cooling Unit	2019	9,877		15	658	658	987	62
63	Water Leak Repair	2020	2,644		7	94	94	94	63
64	Rooftop A/C Unit	2020	11,225		15	374	374	374	64
65	Roof Replacement on South West Wing roof	2020	7,164		25	143	143	143	65
66	Awning	2020	2,959		10	148	148	148	66
67	Water Heater	2020	5,548		7	396	396	396	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,009,074	\$		\$ 80,304	\$ 80,304	\$ 956,198	70

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

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
1	Totals from Page 12A, Carried Forward		\$ 2,009,074	\$		\$ 80,304	\$ 80,304	\$ 956,198	1
2									2
3									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	Land Improvements Booked			5,822			(5,822)		25
26	Building Booked			13,551			(13,551)		26
27	Building Improvement Booked			66,083			(66,083)		27
28									28
29	2020-Home Office Allocation-Building Improvements		19,436			466	466		29
30	2020-Home Office Allocation-Land Improvements		1,950			123	123		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,030,460	\$ 85,456		\$ 80,893	\$ (4,563)	\$ 956,198	34

**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	\$121,367	\$14,846	\$15,951	\$1,105	5-10 yrs.	\$61,143	71
72	Current Year Purchases	8,761	944	626	(318)	7 yrs.	626	72
73	Fully Depreciated Assets	246,638					246,638	73
74	Home Office Allocation			13,609	13,609			74
75	TOTALS	\$376,766	\$15,790	\$30,186	\$14,396		\$308,407	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	\$37,380	\$	\$	\$		\$37,380	76
77	Facility	1999 Ford	2010	9,112					9,112	77
78	Facility	2012 Ford 150 Van	2017	5,000	1,000	1,000		5 yrs.	3,500	78
79	Facility	2019 Dodge Caravan	2020	39,027	3,903	3,903		5 yrs.	3,903	79
80	TOTALS			\$90,519	\$4,903	\$4,903	\$		\$53,895	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)	\$2,530,605	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$106,149	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$115,982	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,833	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,318,500	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			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 210,356 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					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2021 | \$ |
| 13. | /2022 | \$ |
| 14. | /2023 | \$ |

* 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
0052274
Period Beginning **1/1/2020**
Period End **12/31/2020**

Schedule 14A

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

Medical Equipment	\$	3,831
Dishwasher		701
Copier		4,973
Home Office Allocation		<u>200,851</u>
		<u><u>210,356</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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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	2	3	4		5	6	7	8
			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	\$	8,156	\$ 122,342	\$	8,156	\$ 122,342	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,014	45,209		3,014	45,209	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,741	176,113		11,741	176,113	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				36,915		36,915	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			\$	22,911	\$ 343,664	\$ 36,915	22,911	\$ 380,579	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,133,998	\$ 1,133,998	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 114,679)	2,202,940	2,202,940	3
4	Supply Inventory (priced at Cost)	26,521	26,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,284	44,404	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,515	53,919	8
9	Other(specify): Employee Education Loans	600	600	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,401,858	\$ 3,462,382	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		32,860	13
14	Buildings, at Historical Cost		547,928	14
15	Leasehold Improvements, at Historical Cost	106,408	1,482,532	15
16	Equipment, at Historical Cost	122,862	467,285	16
17	Accumulated Depreciation (book methods)	(108,195)	(1,318,500)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		175,661	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(53,870)	20
21	Restricted Funds		1,238,036	21
22	Other Long-Term Assets (specify):	105,388	105,388	22
23	Other(specify): Intercompany Loans	1,577,364	1,644,118	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,803,827	\$ 4,321,438	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,205,685	\$ 7,783,820	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,445,347	\$ 1,581,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,338	144,338	30
31	Accrued Taxes Payable (excluding real estate taxes)	151,113	151,113	31
32	Accrued Real Estate Taxes(Sch.IX-B)		97,824	32
33	Accrued Interest Payable		8,379	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,221	2,221	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,743,019	\$ 1,985,376	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,055	36,055	39
40	Mortgage Payable		3,640,868	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	640,000	640,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 676,055	\$ 4,316,923	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,419,074	\$ 6,302,299	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,786,611	\$ 1,481,521	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,205,685	\$ 7,783,820	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,629,806)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	3,149,732	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (480,074)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,266,685	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)	\$ 3,266,685	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,786,611	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 6,774,300	1
2	Discounts and Allowances for all Levels	(1,092,275)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,682,025	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	572,287	6
7	Oxygen	200	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 572,487	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	3,737	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,121	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,738	20
21	Other Medical Services	3,387	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,983	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	137	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,689	28
28a	<u>Miscellaneous and Stimulus Revenue</u>	2,794,275	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,795,964	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,136,596	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,206,359	31
32	Health Care	2,853,917	32
33	General Administration	913,065	33
	B. Capital Expense		
34	Ownership	415,076	34
	C. Ancillary Expense		
35	Special Cost Centers	164,039	35
36	Provider Participation Fee	317,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,869,911	40
41	Income before Income Taxes (line 30 minus line 40)**	3,266,685	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,266,685	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,435,748	44
45	Private Pay - Net Inpatient Revenue	642,211	45
46	Medicare - Net Inpatient Revenue	578,111	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	25,955	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,682,025	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.

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	874	942	\$ 32,400	\$ 34.39	1
2	Assistant Director of Nursing	444	444	11,140	25.09	2
3	Registered Nurses	12,022	12,444	409,887	32.94	3
4	Licensed Practical Nurses	11,368	11,779	265,233	22.52	4
5	CNAs & Orderlies	59,429	60,853	909,234	14.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,798	1,977	27,831	14.08	9
10	Activity Assistants	3,867	3,947	37,369	9.47	10
11	Social Service Workers	4,737	4,923	67,157	13.64	11
12	Dietician					12
13	Food Service Supervisor	2,116	2,116	44,519	21.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,290	18,976	200,967	10.59	15
16	Dishwashers					16
17	Maintenance Workers	5,875	5,985	97,859	16.35	17
18	Housekeepers	13,031	13,307	157,253	11.82	18
19	Laundry	3,970	4,122	41,777	10.14	19
20	Administrator	2,080	2,080	77,004	37.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,835	1,995	35,800	17.94	23
24	Clerical	4,800	4,878	57,367	11.76	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	1,020	1,026	26,733	26.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	11,895	12,397	330,946	26.70	33
34	TOTAL (lines 1 - 33)	159,451	164,191	\$ 2,830,476 *	\$ 17.24	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	18	\$ 917	L1, C3	35
36	Medical Director	Monthly	30,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,821	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) <u>Telehealth</u>	Monthly	46,700	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	18	\$ 89,438		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	105	\$ 8,205	L10,C3	50
51	Licensed Practical Nurses	2,460	123,074	L10,C3	51
52	Certified Nurse Assistants/Aides	1,129	31,585	L10,C3	52
53	TOTAL (lines 50 - 52)	3,694	\$ 162,864		53

Palm Terrace of Mattoon
0052274
Period Beginning 1/1/2020
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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	2,579	2,724	88,314	32.42
Transportation	2,080	2,080	25,894	12.45
Restorative Aides	1,222	1,338	21,356	15.96
Psych Assistants	1,674	1,736	50,834	29.28
Alzheimer's Coordinator	4,340	4,519	144,548	31.99
TOTAL	11,895	12,397	330,946	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Janelle Holthaus	Administrator	0	\$ 77,004	Workers' Compensation Insurance	\$	43,102	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		30,202	Advertising: Employee Recruitment		
				FICA Taxes		206,682	Health Care Worker Background Check		
				Employee Health Insurance		15,122	(Indicate # of checks performed 33)		
				Employee Meals			Patient Background Checks	58 1,743	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	1,107	
				Employee Relations		1,168	Miscellaneous Dues & Subscriptions	0	
				Home Office Allocation		17,422	Home Office Allocation	5,240	
				Employee Retirement		797			
				Administrator Benefits		15,396			
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 77,004				Non-allowable advertising	()	
B. Administrative - Other							Yellow page advertising	()	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 317,500	\$ 329,891			\$ 10,080		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 317,500	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mediacom	Computer Services	\$	1,602			\$	Out-of-State Travel	\$	
Livingston, Barger, Brandt	Legal Fees-1/20/2020		815						
Ability Network	Computer Services		8,201						
Allscripts	Data Services		2,273				In-State Travel		
Regions Bank	Legal Filing Fees-7/14/20		58						
				N/A					
							Seminar Expense		
							Home Office Allocation	33	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 12,949				TOTAL 33		

*** Attach copy of IMRF notifications**

****See instructions.**

Palm Terrace of Mattoon
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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)		12,949
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	592
Duane Morris	Legal	12,679
Lexis Nexis	Legal	16
Livingston, Barger, Brant, Schroeder	Legal	4,519
Miller, Hall, Triggs	Legal	102
Miscellaneous	Legal	38
SB2	Legal	306
SmithAmundsen LLC	Legal	1,891
Sorling Northrup	Legal	539
Mauer and Madoff	Legal	882
Illinois Secretary of State	Legal	266
Sedgwick Claims Management	Legal	14,708
Huntington Bank	Legal	300
CliftonLarsonAllen	Accounting	11,436
Ginoli & Co.	Accounting	8,819
Ability Network	Computer Services	6,034
Allscripts	Computer Services	952
AOD Matrix Care	Computer Services	10,597
AT&T	Computer Services	11
ATS	Computer Services	578
CCH	Computer Services	34
Charter Communications	Computer Services	53
Citrix Systems	Computer Services	180
Comcast	Computer Services	62
ITSavvy	Computer Services	279
Kemper Technology	Computer Services	1,377
Miscellaneous	Computer Services	267
Pearl Technology	Computer Services	249
Stratus Networks	Computer Services	1,094
TR Professional	Computer Services	23
David Budde	Other Prof Fees	24
DJ Howard and Associates	Other Prof Fees	46
Getzler Henrich & Associates	Other Prof Fees	186
LRI Consulting Services	Other Prof Fees	181
McQuellon Consulting	Other Prof Fees	115
Miscellaneous	Other Prof Fees	219
Optimizer	Other Prof Fees	98
Registered Agent Solutions	Other Prof Fees	55
RSM McGladrey	Other Prof Fees	599
SB2	Other Prof Fees	4,442
Sedgwick CMS	Other Prof Fees	6,267
Tarver Program Consultants	Other Prof Fees	143
Total (agree to Schedule V, line 19, column 8)		<u>104,207</u>

Palm Terrace of Mattoon
0052274
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Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	2,104
Auto Repairs		3,132
Mileage-Travel		-
Home Office Allocation		<u>7,333</u>
		<u><u>12,569</u></u>

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?
If YES, give association name and amount. No
- (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?
What was the average life used for new equipment added during this period? Yes
7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,173 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. \$ 317,455
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. \$ 3,737
- (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. \$ 1,689
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (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. No
Attach invoices and a summary of services for all architect and appraisal fees.