

Facility Name & ID Number Palm Terrace of Mattoon

0046037 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	40,966	5,476	2,065	48,507	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,966	5,476	2,065	48,507	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.66%

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

0 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 14 and days of care provided 1,573

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Palm Terrace of Mattoon # 0046037 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	178,114	16,329		194,443		194,443	3,450	197,893		1
2	Food Purchase		225,802		225,802		225,802	(7,425)	218,377		2
3	Housekeeping	159,132	44,002		203,134		203,134	153	203,287		3
4	Laundry	57,875	15,179		73,054		73,054		73,054		4
5	Heat and Other Utilities			183,020	183,020		183,020	640	183,660		5
6	Maintenance	56,701	68,899	23,849	149,449		149,449	8,772	158,221		6
7	Other (specify):* Home office benefit							1,382	1,382		7
8	TOTAL General Services	451,822	370,211	206,869	1,028,902		1,028,902	6,972	1,035,874		8
	B. Health Care and Programs										
9	Medical Director			34,950	34,950		34,950		34,950		9
10	Nursing and Medical Records	1,539,705	132,194	375	1,672,274		1,672,274	12,471	1,684,745		10
10a	Therapy			73,406	73,406		73,406	1,145	74,551		10a
11	Activities	66,746	3,530	2,476	72,752		72,752		72,752		11
12	Social Services	160,327	191		160,518		160,518		160,518		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home office benefit							3,855	3,855		15
16	TOTAL Health Care and Programs	1,766,778	135,915	111,207	2,013,900		2,013,900	17,471	2,031,371		16
	C. General Administration										
17	Administrative	69,250		170,000	239,250		239,250	(136,004)	103,246		17
18	Directors Fees										18
19	Professional Services			24,671	24,671		24,671	13,812	38,483		19
20	Dues, Fees, Subscriptions & Promotions			14,486	14,486		14,486	920	15,406		20
21	Clerical & General Office Expenses	25,111	8,757	24,010	57,878		57,878	52,355	110,233		21
22	Employee Benefits & Payroll Taxes			327,427	327,427		327,427	3,930	331,357		22
23	Inservice Training & Education			295	295		295	443	738		23
24	Travel and Seminar			760	760		760		760		24
25	Other Admin. Staff Transportation			21,331	21,331		21,331	3,530	24,861		25
26	Insurance-Prop.Liab.Malpractice			51,450	51,450		51,450	2,612	54,062		26
27	Other (specify):* Home office benefit							9,685	9,685		27
28	TOTAL General Administration	94,361	8,757	634,430	737,548		737,548	(48,717)	688,831		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,312,961	514,883	952,506	3,780,350		3,780,350	(24,274)	3,756,076		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Palm Terrace of Mattoon

#0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			71,253	71,253		71,253	3,268	74,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			299,539	299,539		299,539	54,083	353,622			32
33	Real Estate Taxes			49,388	49,388		49,388	1,584	50,972			33
34	Rent-Facility & Grounds							1,535	1,535			34
35	Rent-Equipment & Vehicles			13,311	13,311		13,311	805	14,116			35
36	Other (specify):*											36
37	TOTAL Ownership			433,491	433,491		433,491	61,275	494,766			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,886	4,715	34,601		34,601		34,601			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):* Nonallowable Cost			100,821	100,821		100,821	(100,821)				43
44	TOTAL Special Cost Centers		29,886	202,991	232,877		232,877	(100,821)	132,056			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,312,961	544,769	1,588,988	4,446,718		4,446,718	(63,820)	4,382,898			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,967)	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	(10,244)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,337)	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	(1,228)	43		18
19	Entertainment				19
20	Contributions	(568)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,956)	43		24
25	Fund Raising, Advertising and Promotional	(13,815)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(37,949)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,064)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	68,244	var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 68,244		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (63,820)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Palm Terrace of Mattoon

ID# 0046037

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (806)	43	1
2	Labs - Part A	(2,174)	43	2
3	X-Rays - Part A	(425)	43	3
4	Vending Machine Expense	(500)	2	4
5	Special Events	(7,118)	43	5
6	Offset Cable TV revenue	(6,427)	43	6
7	Offset meal revenue	(3,165)	2	7
8	Offset misc. revenue	(2,448)	21	8
9	Rotary and Chamber of Commerce dues	(539)	20	9
10	Nonallowable architecture fees	(1,077)	19	10
11	Nonallowable travel expense	(13,270)	24	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	(37,949)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	3,450	0	0	0	0	0	0	0	0	0	3,450	1
2	Food Purchase	(3,665)	170	0	0	0	0	0	0	0	0	0	(3,495)	2
3	Housekeeping	0	153	0	0	0	0	0	0	0	0	0	153	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	640	0	0	0	0	0	0	0	0	0	640	5
6	Maintenance	0	8,772	0	0	0	0	0	0	0	0	0	8,772	6
7	Other (specify):*	0	1,382	0	0	0	0	0	0	0	0	0	1,382	7
8	TOTAL General Services	(3,665)	14,567	0	0	0	0	0	0	0	0	0	10,902	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	12,471	0	0	0	0	0	0	0	0	0	12,471	10
10a	Therapy	0	1,145	0	0	0	0	0	0	0	0	0	1,145	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	3,855	0	0	0	0	0	0	0	0	0	3,855	15
16	TOTAL Health Care and Programs	0	17,471	0	0	0	0	0	0	0	0	0	17,471	16
	C. General Administration													
17	Administrative	0	(136,004)	0	0	0	0	0	0	0	0	0	(136,004)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,077)	14,889	0	0	0	0	0	0	0	0	0	13,812	19
20	Fees, Subscriptions & Promotions	(539)	1,459	0	0	0	0	0	0	0	0	0	920	20
21	Clerical & General Office Expenses	(2,448)	0	54,803	0	0	0	0	0	0	0	0	52,355	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	443	0	0	0	0	0	0	0	0	443	23
24	Travel and Seminar	(13,270)	0	13,270	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	3,530	0	0	0	0	0	0	0	0	3,530	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,612	0	0	0	0	0	0	0	0	2,612	26
27	Other (specify):*	0	0	9,685	0	0	0	0	0	0	0	0	9,685	27
28	TOTAL General Administration	(17,334)	(119,656)	84,343	0	(52,647)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,999)	(87,618)	84,343	0	(24,274)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(10,244)	0	13,512	0	0	0	0	0	0	0	0	3,268	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	54,083	0	0	0	0	0	0	0	0	54,083	32
33	Real Estate Taxes	0	0	1,584	0	0	0	0	0	0	0	0	1,584	33
34	Rent-Facility & Grounds	0	0	1,535	0	0	0	0	0	0	0	0	1,535	34
35	Rent-Equipment & Vehicles	0	0	805	0	0	0	0	0	0	0	0	805	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,244)	0	71,519	0	61,275	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(100,821)	0	0	0	0	0	0	0	0	0	0	(100,821)	43
44	TOTAL Special Cost Centers	(100,821)	0	0	0	0	0	0	0	0	0	0	(100,821)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(132,064)	(87,618)	155,862	0	(63,820)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

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%	\$ 3,450	\$ 3,450	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	170	170	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	153	153	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	640	640	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	8,772	8,772	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,382	1,382	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	12,471	12,471	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	1,145	1,145	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,855	3,855	10
11	V	17 Administrative	170,000	Petersen Health Care, Inc.	100.00%	33,996	(136,004)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	14,889	14,889	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,459	1,459	13
14	Total		\$ 170,000			\$ 82,382	\$ * (87,618)	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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 54,803	\$	54,803	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	443		443	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	13,270		13,270	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,530		3,530	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	2,612		2,612	19
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,685		9,685	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	13,512		13,512	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	54,083		54,083	22
23	V	33 Real Estate Tax		Petersen Health Care, Inc.	100.00%	1,584		1,584	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,535		1,535	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	805		805	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 155,862	\$ *	155,862	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:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Sch 7A	2.12	4.25	Salary	\$ 33,996	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 33,996		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/06

Ending: 12/31/06

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, Inc.
 Street Address 830 West 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 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	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	48,507	\$ 3,450	1
2	2	Food	Patient Days	1,141,463	56	3,989		48,507	170	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		48,507	153	3
4	5	Utilities	Patient Days	1,141,463	56	15,054		48,507	640	4
5	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	48,507	8,772	5
6	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		48,507	1,382	6
7	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	48,507	12,471	7
8	10A	Therapy	Patient Days	1,141,463	56	26,945		48,507	1,145	8
9	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		48,507	3,855	9
10	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	48,507	33,996	10
11	19	Professional Services	Patient Days	1,141,463	56	350,361		48,507	14,889	11
12	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		48,507	1,459	12
13	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	48,507	54,803	13
14	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		48,507	443	14
15	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		48,507	13,270	15
16	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		48,507	3,530	16
17	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		48,507	2,612	17
18	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		48,507	9,685	18
19	30	Depreciation	Patient Days	1,141,463	56	317,964		48,507	13,512	19
20	32	Interest	Patient Days	1,141,463	56	176,614		48,507	7,505	20
21	32a	Interest	Patient Days	316,605	56	304,014		48,507	46,578	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		48,507	1,584	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		48,507	1,535	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		48,507	805	24
25	TOTALS					\$ 4,814,249	\$ 2,234,999		\$ 238,244	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Associated Bank		X	Vehicle	\$544.28	5/9/03	\$ 18,000		05/09/08	0.0550	\$ 70	1						
2	US Bank		X	Mortgage	\$52,952+interest	12/31/04	4,448,000	4,238,480	12/31/11	0.0699	299,469	2						
3												3						
4								Home Office Allocation			54,083	4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$544.28		\$ 4,466,000	\$ 4,238,480			\$ 353,622	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,466,000	\$ 4,238,480			\$ 353,622	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-1-00908-000</u>	<u>Palm Terrace of Mattoon</u>	\$ <u>39,336.06</u>	\$ <u>39,339.06</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,584.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>39,336.06</u>	\$ <u>40,923.06</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,000 B. General Construction Type: Exterior Brick & Block Frame _____ 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Palm Terrace of Mattoon**# **0046037**

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	178		2002	1969	\$ 528,492	\$	39	\$ 13,551	\$ 13,551	\$ 51,946	4
5											5
6	Allocation										6
7	From Home			2006	28,930			1,266	1,266	1,266	7
8	Office										8
	Improvement Type**										
9	Alzheimer's unit renovation			2003	4,026		15	268	268	827	9
10	Alzheimer's unit renovation			2003	26,810		15	1,787	1,787	5,511	10
11	Roof			2004	7,814		35	223	223	465	11
12	Boiler			2004	4,019		35	115	115	230	12
13	Alzheimer's wing renovation per cap proj			2005	312,682		30	10,423	10,423	15,634	13
14	New roof			2005	36,428		30	1,214	1,214	1,518	14
15	New flooring			2005	27,858		10	2,786	2,786	3,018	15
16	Windows			2006	3,375		25	68	68	68	16
17	Sidewalks			2006	2,980		15	99	99	99	17
18	Asphalt			2006	43,960		15	1,465	1,465	1,465	18
19	Sidewalks			2006	6,300		15	210	210	210	19
20	86 - Smoke			2006	7,545		7	539	539	539	20
21	Roof			2006	68,274		25	1,365	1,365	1,365	21
22	Tile Flooring			2006	1,648		25	33	33	33	22
23	New roof			2006	3,145		30	52	52	52	23
24	Land Improvement Booked					2,977			(2,977)		24
25	Building Booked					13,551			(13,551)		25
26	Building Improvement Booked					20,945			(20,945)		26
27											27
28	Home Office Allocation - Land Improvements			2006	1,672			155	155	155	28
29	Home Office Allocation - Building Improvements			2006	47			3	3	3	29
30											30
31	Alzheimer's wing renovation- contractors application #6			2005	39,645		30	1,322	1,322	1,983	31
32	Alzheimer's wing renovation - arch. Fees			2005	1,157		30	39	39	58	32
33	Alzheimer's wing renovation- contractors application #7			2005	4,252		30	142	142	213	33
34	Alzheimer's wing - doors and hardware			2005	1,063		30	35	35	53	34
35	Alzheimer's wing renovation- fire system			2005	1,485		30	50	50	75	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	1,163,607	\$	37,474	\$	37,210	\$	(264)	\$	86,786	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 153,457	\$ 24,767	\$ 15,347	\$ (9,420)	3-10	\$ 40,551	71
72	Current Year Purchases	48,246		2,400	2,400	3-10	2,400	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			12,088	12,088			74
75	TOTALS	\$ 201,703	\$ 24,767	\$ 29,835	\$ 5,068		\$ 42,951	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Jetta	2003	\$ 17,080	\$ 3,416	\$ 3,416	\$	5	\$ 11,956	76
77	Facility	2003 Dodge Truck	2003	20,300	4,060	4,060		5	13,872	77
78										78
79	Disposed-2006	2000 Ford Truck			1,536		(1,536)			79
80	TOTALS			\$ 37,380	\$ 9,012	\$ 7,476	\$ (1,536)		\$ 25,828	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,435,550	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,253	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,521	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,268	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 155,565	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>1,535</u>			6
7	TOTAL				\$ <u>1,535</u>			7

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

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

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: \$ 14,116 Description: See schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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
Provider #0046307
12/31/2005

Schedule 14A

XII. Rental Equipment
Line 16

<u>Type of Equipment</u>	<u>Cost</u>
Copier	5377
Dishwasher	180
Maint. Equip	35
Nursing	7539
Home Ofc.	805
Laundry eqpt.	180
	<u>\$ 14,116</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	329	\$ 26,350	\$	329	\$ 26,350	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		118	10,109		118	10,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		480	36,947	1,145	480	38,092	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				29,886		29,886	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	L39, C3			187	4,715		187	4,715	12
13	Other (specify):									13
14	TOTAL			\$	1,114	\$ 78,121	\$ 31,031	1,114	\$ 109,152	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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	\$ 3,622,354	\$ 3,622,354	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,112,029	1,112,029	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,688	5,688	6
7	Other Prepaid Expenses	7,846	7,846	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	612,189	612,189	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,360,106	\$ 5,360,106	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,126	32,860	13
14	Buildings, at Historical Cost	1,072,547	1,163,607	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	239,083	239,083	16
17	Accumulated Depreciation (book methods)	(175,001)	(155,565)	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 (specify): _____			22
23	Other(specify): <u>Security Deposit</u>	998	998	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,227,753	\$ 1,280,983	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,587,859	\$ 6,641,089	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 445,506	\$ 445,506	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,104	118,104	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,214	7,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,500	39,500	32
33	Accrued Interest Payable	24,487	24,487	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Withholdings</u>	27,758	27,758	36
37	<u>Due to Related Parties</u>	89,880	89,880	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 752,449	\$ 752,449	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,238,480	4,238,480	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,238,480	\$ 4,238,480	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,990,929	\$ 4,990,929	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,596,930	\$ 1,650,160	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,587,859	\$ 6,641,089	48

**Palm Terrace of Mattoon
Provider #0046307
12/31/2005**

Schedule 17A

Schedule 17A

XV. Balance Sheet - Unrestricted Operating Funds

A. Current Assets

<u>Other Current Assets:</u>	<u>Operating</u>	<u>Consolidation</u>
Education Loans	1,189	1,189
Due from related parties	611,000	611,000
Total Line 9 - Other Current Assets	<u>612,189</u>	<u>612,189</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 920,006	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(31,361)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 888,645	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	708,288	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) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 708,285	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)	\$ 1,596,930	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,789,148	1
2	Discounts and Allowances for all Levels	186,130	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,975,278	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,147	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 106,147	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	3,165	14
15	Telephone, Television and Radio	6,427	15
16	Rental of Facility Space		16
17	Sale of Drugs	55,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,414	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 68,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	500	28
28a	Misc.-\$2448, Gain/Loss: Prop & Equipt.-\$2141	4,589	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,089	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,155,006	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,028,902	31
32	Health Care	2,013,900	32
33	General Administration	737,548	33
	B. Capital Expense		
34	Ownership	433,491	34
	C. Ancillary Expense		
35	Special Cost Centers	135,422	35
36	Provider Participation Fee	97,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,446,718	40
41	Income before Income Taxes (line 30 minus line 40)**	708,288	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 708,288	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer

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

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

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,340	2,340	\$ 48,108	\$ 20.56	1
2	Assistant Director of Nursing	1,601	1,641	34,281	20.89	2
3	Registered Nurses	5,850	6,163	115,400	18.73	3
4	Licensed Practical Nurses	24,314	25,598	417,952	16.33	4
5	CNAs & Orderlies	86,773	90,160	887,269	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,966	2,966	33,786	11.39	9
10	Activity Assistants	1,980	2,044	15,899	7.78	10
11	Social Service Workers	10,867	11,074	160,327	14.48	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,159	18.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,385	18,154	138,955	7.65	15
16	Dishwashers					16
17	Maintenance Workers	5,448	5,504	56,701	10.30	17
18	Housekeepers	23,677	24,015	159,132	6.63	18
19	Laundry	6,947	7,283	57,875	7.95	19
20	Administrator	2,080	2,080	69,250	33.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	25,111	12.07	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	174	174	1,132	6.50	31
32	Other Health Care: Care Plan Coordinators	2,001	2,025	35,564	17.56	32
33	Other(specify) <u>Transportation</u>	1,905	2,001	17,061	8.53	33
34	TOTAL (lines 1 - 33)	200,466	207,381	\$ 2,312,961 *	\$ 11.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	monthly	34,950	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	375	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,325		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Palm Terrace of Mattoon**

0046037

Report Period Beginning: **01/01/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Karla Schneider	Administrator	0	\$ 69,250	Workers' Compensation Insurance	\$ 57,543	IDPH License Fee	\$ 10,817		
				Unemployment Compensation Insurance	53,119	Advertising: Employee Recruitment	174		
				FICA Taxes	171,188	Health Care Worker Background Check (Indicate # of checks performed <u>211</u>)	2,530		
				Employee Health Insurance	24,852	Patient Background Checks			
				Employee Meals	3,930	Misc Dues	426		
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	1,459		
				Employee Retirement	1,041				
				Employee Relations	10,145				
				Employee Life Insurance	9,539				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,250	TOTAL (agree to Schedule V, line 22, col.8)		\$ 331,357	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,406
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fee (eliminated in column 7)			\$ 170,000	N/A			Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	760	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 170,000	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
C. Professional Services							TOTAL		
Vendor/Payee	Type		Amount				\$ 760		
Altschuler, Melvoin & Glasser, LLP	Accounting		5,850						
RSM	Accounting		1,075						
Lindon Engineering	Cost Segregation		3,278						
Heyl Royster Voelker & Allen	Legal		9,262						
Farnsworth Group	Architect		1,607						
Greg Wilson	Computer Services		319						
IVANS	Computer Services		141						
LTC Solutions	Computer Services		2,640						
Emdeon Business Services	Computer Services		499						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,671						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Palm Terrace of Mattoon
Provider Number - 0046307
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 23,594

Allocated from Home Office

Other Professional Fees	14,691	
Legal	198	
Home Office Architect Fee Offset, per Sch VI	<u>(1,077)</u>	<u>13,812</u>

Total (agree to Schedule V, line 19, column 8) 37,406

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5					N/A								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 01/01/06Ending: 12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,849 Line 10,2
- (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. \$ 97,455
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 3,930 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,165
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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