

Facility Name & ID Number Palm Terrace of Mattoon

0046037 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	43,324	5,452	2,761	51,537	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,324	5,452	2,761	51,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.32%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 11/1/2002

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/2002 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 178 and days of care provided 2,501

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Palm Terrace of Mattoon # 0046037 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	187,444	25,822		213,266		213,266	4,313	217,579		1
2	Food Purchase		272,560		272,560		272,560	(4,224)	268,336		2
3	Housekeeping	188,288	42,879		231,167		231,167	49	231,216		3
4	Laundry	66,926	17,639		84,565		84,565	3	84,568		4
5	Heat and Other Utilities			227,525	227,525		227,525	736	228,261		5
6	Maintenance	76,141	36,979	30,953	144,073		144,073	7,213	151,286		6
7	Other (specify):* Home Off. Ben. All.							1,968	1,968		7
8	TOTAL General Services	518,799	395,879	258,478	1,173,156		1,173,156	10,058	1,183,214		8
	B. Health Care and Programs										
9	Medical Director			37,000	37,000		37,000		37,000		9
10	Nursing and Medical Records	1,642,929	81,495	2,429	1,726,853		1,726,853	9,882	1,736,735		10
10a	Therapy		93	264,371	264,464		264,464		264,464		10a
11	Activities	71,623	1,273	400	73,296		73,296	(1,002)	72,294		11
12	Social Services	151,065	16		151,081		151,081		151,081		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,535	2,535		15
16	TOTAL Health Care and Programs	1,865,617	82,877	304,200	2,252,694		2,252,694	11,415	2,264,109		16
	C. General Administration										
17	Administrative	85,084		200,000	285,084		285,084	(167,896)	117,188		17
18	Directors Fees										18
19	Professional Services			49,415	49,415		49,415	14,593	64,008		19
20	Dues, Fees, Subscriptions & Promotions			17,482	17,482		17,482	2,412	19,894		20
21	Clerical & General Office Expenses	28,572	11,129	15,430	55,131		55,131	88,007	143,138		21
22	Employee Benefits & Payroll Taxes			414,695	414,695		414,695	16,881	431,576		22
23	Inservice Training & Education			2,399	2,399		2,399	886	3,285		23
24	Travel and Seminar			456	456		456	1,406	1,862		24
25	Other Admin. Staff Transportation			16,040	16,040		16,040	8,074	24,114		25
26	Insurance-Prop.Liab.Malpractice			35,252	35,252		35,252	5,073	40,325		26
27	Other (specify):* Home Off. Ben. All.							20,902	20,902		27
28	TOTAL General Administration	113,656	11,129	751,169	875,954		875,954	(9,662)	866,292		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,498,072	489,885	1,313,847	4,301,804		4,301,804	11,811	4,313,615		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

#0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			79,758	79,758		79,758	25,315	105,073			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			291,369	291,369		291,369	38,969	330,338			32
33	Real Estate Taxes			38,796	38,796		38,796	1,687	40,483			33
34	Rent-Facility & Grounds							104	104			34
35	Rent-Equipment & Vehicles			11,460	11,460		11,460	1,400	12,860			35
36	Other (specify):*											36
37	TOTAL Ownership			421,383	421,383		421,383	67,475	488,858			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,486		88,486		88,486		88,486			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):* Non-allowable Cost		976	175,212	176,188		176,188	(176,188)				43
44	TOTAL Special Cost Centers		89,462	272,667	362,129		362,129	(176,188)	185,941			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,498,072	579,347	2,007,897	5,085,316		5,085,316	(96,902)	4,988,414			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.

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,373)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,847)	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	(9,672)	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	(1,092)	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	(2,072)	43		18
19	Entertainment				19
20	Contributions	(847)	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	(140,171)	43		24
25	Fund Raising, Advertising and Promotional	(12,606)	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	(13,533)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (194,213)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	97,311	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 97,311		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,902)		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

Palm Terrace of Mattoon

ID# 0046037

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,617)	43	1
2	X-Rays-Part A	(2,653)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,521)	10	3
4	Offset Transportation Revenue	(1,002)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(613)	21	5
6	Offset Chamber of Commerce Dues	(844)	20	6
7	Resident Flower	(1,245)	43	7
8	Disallowed Special Events	(4,038)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,533)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	4,313	0	0	0	0	0	0	0	0	0	4,313	1
2	Food Purchase	(4,373)	149	0	0	0	0	0	0	0	0	0	(4,224)	2
3	Housekeeping	0	49	0	0	0	0	0	0	0	0	0	49	3
4	Laundry	0	3	0	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	736	0	0	0	0	0	0	0	0	0	736	5
6	Maintenance	0	6,008	0	1,205	0	0	0	0	0	0	0	7,213	6
7	Other (specify):*	0	1,968	0	0	0	0	0	0	0	0	0	1,968	7
8	TOTAL General Services	(4,373)	13,226	0	1,205	0	10,058	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	(1,521)	11,403	0	0	0	0	0	0	0	0	0	9,882	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,002)	0	0	0	0	0	0	0	0	0	0	(1,002)	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	2,535	0	0	0	0	0	0	0	0	0	2,535	15
16	TOTAL Health Care and Programs	(2,523)	13,938	0	0	0	0	0	0	0	0	0	11,415	16
	C. General Administration													
17	Administrative	0	(167,896)	0	0	0	0	0	0	0	0	0	(167,896)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,715	0	5,878	0	0	0	0	0	0	0	14,593	19
20	Fees, Subscriptions & Promotions	(844)	0	1,889	1,367	0	0	0	0	0	0	0	2,412	20
21	Clerical & General Office Expenses	(613)	0	73,102	15,518	0	0	0	0	0	0	0	88,007	21
22	Employee Benefits & Payroll Taxes	0	0	0	16,881	0	0	0	0	0	0	0	16,881	22
23	Inservice Training & Education	0	0	841	45	0	0	0	0	0	0	0	886	23
24	Travel and Seminar	0	0	1,338	68	0	0	0	0	0	0	0	1,406	24
25	Other Admin. Staff Transportation	0	0	4,848	3,226	0	0	0	0	0	0	0	8,074	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,974	3,099	0	0	0	0	0	0	0	5,073	26
27	Other (specify):*	0	0	20,902	0	0	0	0	0	0	0	0	20,902	27
28	TOTAL General Administration	(1,457)	(159,181)	104,894	46,082	0	(9,662)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,353)	(132,017)	104,894	47,287	0	11,811	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Palm Terrace of Mattoon# 0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(9,672)	0	5,119	29,868	0	0	0	0	0	0	0	25,315	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,898	30,071	0	0	0	0	0	0	0	38,969	32
33	Real Estate Taxes	0	0	1,687	0	0	0	0	0	0	0	0	1,687	33
34	Rent-Facility & Grounds	0	0	104	0	0	0	0	0	0	0	0	104	34
35	Rent-Equipment & Vehicles	0	0	1,358	42	0	0	0	0	0	0	0	1,400	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,672)	0	17,166	59,981	0	67,475	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):*	(176,188)	0	0	0	0	0	0	0	0	0	0	(176,188)	43
44	TOTAL Special Cost Centers	(176,188)	0	0	0	0	0	0	0	0	0	0	(176,188)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(194,213)	(132,017)	122,060	107,268	0	(96,902)	45						

Facility Name & ID Number

Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,313	\$ 4,313	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	149	149	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	49	49	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	736	736	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	6,008	6,008	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,968	1,968	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	11,403	11,403	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,535	2,535	10
11	V	17 Administrative	200,000	Petersen Health Care, Inc.	100.00%	32,104	(167,896)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,715	8,715	12
13	V							13
14	Total		\$ 200,000			\$ 67,983	\$ * (132,017)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,889	\$	1,889	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	73,102		73,102	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	841		841	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,338		1,338	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,848		4,848	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,974		1,974	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	20,902		20,902	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,119		5,119	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,898		8,898	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,687		1,687	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	104		104	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,358		1,358	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		\$			\$ 122,060	\$ *	122,060	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:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	0
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	0
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	0
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,205	1,205
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	0
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	5,878	5,878
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,367	1,367
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	15,518	15,518
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	16,881	16,881
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	45	45
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	68	68
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,226	3,226
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	3,099	3,099
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	29,868	29,868
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	30,071	30,071
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	42	42
39	Total		\$			\$ 107,268	\$ * 107,268

* 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:

01/01/2007

Ending:

12/31/2007

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 Schedule 7A	2.11	3.84	Salary	\$ 32,104	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	\$ 32,104		13

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

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

Facility Name & ID Number Palm Terrace of Mattoon# 0046037 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 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 Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	51,537	\$ 4,313	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	51,537	149	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	51,537	49	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	51,537	3	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	51,537	736	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	51,537	6,008	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	51,537	1,968	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	51,537	11,403	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	51,537	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	51,537	2,535	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	51,537	32,104	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	51,537	8,715	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	51,537	1,889	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	51,537	73,102	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	51,537	841	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	51,537	1,338	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	51,537	4,848	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	51,537	1,974	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	51,537	20,902	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	51,537	5,119	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	51,537	8,898	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	51,537	1,687	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	51,537	104	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	51,537	1,358	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 190,043	25

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Petersen Health Care II, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	340,686	11	\$	51,537	\$	1
2	2	Food	Resident Days	340,686	11		51,537		2
3	3	Housekeeping	Resident Days	340,686	11		51,537		3
4	4	Laundry	Resident Days	340,686	11		51,537		4
5	5	Utilities	Resident Days	340,686	11		51,537		5
6	6	Maintenance	Resident Days	340,686	11	7,966	51,537	1,205	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		51,537		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		51,537		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		51,537		9
10	17	Administrative	Resident Days	340,686	11		51,537		10
11	19	Professional Services	Resident Days	340,686	11	38,857	51,537	5,878	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	51,537	1,367	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	51,537	15,518	13
14	22	Employee Benefits & Payroll	Resident Days	340,686	11	111,591	51,537	16,881	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	51,537	45	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	51,537	68	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	51,537	3,226	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	51,537	3,099	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		51,537		19
20	30	Depreciation	Resident Days	340,686	11	197,442	51,537	29,868	20
21	32	Interest	Resident Days	340,686	11	198,787	51,537	30,071	21
22	33	Real Estate Taxes	Resident Days	340,686	11		51,537		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		51,537		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	51,537	42	24
25	TOTALS					\$ 709,099	\$	\$ 107,268	25

Facility Name & ID Number

Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	US Bank		X	Mortgage	\$52,952 + int.	12/31/04	\$ 4,448,000	\$ 4,117,518	12/31/11	0.0699	\$ 291,369	1						
2												2						
3												3						
4							Home Office Allocation-PHC				8,898	4						
5							Home Office Allocation-PHC II				30,071	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,448,000	\$ 4,117,518			\$ 330,338	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,448,000	\$ 4,117,518			\$ 330,338	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	39,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	38,296	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,204)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,000	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. Home Office Allocation			1,687	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	40,483	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	28,492	8
	2003	29,431	9
	2004	38,443	10
	2005	39,339	11
	2006	38,296	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>Long-Term Care Facility</u>	\$ <u>38,296.00</u>	\$ <u>38,296.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,296.00</u>	\$ <u>38,296.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,000 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

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

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 65,497	4
5											5
6											6
7	Home Office Allocation				28,732			701	701		7
8											8
	Improvement Type**										
9	Alzheimer's unit renovation		2003		4,026		15	268	268	1,095	9
10	Alzheimer's unit renovation		2003		26,810		15	1,787	1,787	7,298	10
11	Roof		2004		7,814		35	223	223	688	11
12	Boiler		2004		4,019		35	115	115	345	12
13	Alzheimer's wing renovation per cap proj		2005		312,682		30	10,423	10,423	26,057	13
14	New roof		2005		36,428		30	1,214	1,214	2,732	14
15	New flooring		2005		27,858		10	2,786	2,786	5,804	15
16	Windows		2006		3,375		25	135	135	203	16
17	Sidewalks		2006		2,980		15	199	199	298	17
18	Asphalt		2006		43,960		15	2,931	2,931	4,396	18
19	Sidewalks		2006		6,300		15	420	420	630	19
20	86 - Smoke		2006		7,545		7	1,078	1,078	1,617	20
21	Roof		2006		68,274		25	2,731	2,731	4,096	21
22	Tile Flooring		2006		1,648		25	66	66	99	22
23	New roof		2006		3,145		30	105	105	157	23
24	Alzheimer's wing renovation- contractors application #6		2005		39,645		30	1,322	1,322	3,305	24
25	Alzheimer's wing renovation - arch. Fees		2005		1,157		30	39	39	97	25
26	Alzheimer's wing renovation- contractors application #7		2005		4,252		30	142	142	355	26
27	Alzheimer's wing - doors and hardware		2005		1,063		30	35	35	88	27
28	Alzheimer's wing renovation- fire system		2005		1,485		30	50	50	125	28
29	Sidewalks		2007		9,988		15	333	333	333	29
30	Road Work		2007		3,803		15	127	127	127	30
31	Blinds		2007		2,556		10	128	128	128	31
32	Rooftop A/C Unit		2007		5,123		10	256	256	256	32
33	Fire Alarm		2007		5,244		10	262	262	262	33
34	New roof		2007		40,644		30	677	677	677	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	Building Booked		13,551			(13,551)		47
48	Building Improvement Booked		29,846			(29,846)		48
49								49
50								50
51								51
52	2007-Home Office Allocation-Building Improvements	1,922			114	114		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)	\$ 1,230,970	\$ 43,397		\$ 42,218	\$ (1,179)	\$ 126,765	70

**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	\$ 201,703	\$ 27,590	\$ 20,171	\$ (7,419)	3-10	\$ 63,122	71
72	Current Year Purchases	20,715	1,295	1,036	(259)	10	1,036	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			34,172	34,172			74
75	TOTALS	\$ 222,418	\$ 28,885	\$ 55,379	\$ 26,494		\$ 64,158	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	\$ 15,372	76
77	Facility	2003 Dodge Truck	2003	20,300	4,060	4,060		5	17,932	77
78										78
79										79
80	TOTALS			\$ 37,380	\$ 7,476	\$ 7,476	\$		\$ 33,304	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)	\$ 1,523,628	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,073	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,315	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 224,227	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.

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>104</u>			6
7	TOTAL				\$ <u>104</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 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,860 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			\$	\$	17
18			<u>N/A</u>		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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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

0046037

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	5,087
Dishwasher		852
Laundry Equipment		113
Maintenance Equipment		45
Copier		5,363
Home Office Allocation		1,400
		<u>12,860</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,307	\$ 64,611	\$	4,307	\$ 64,611	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,520	22,803		1,520	22,803	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)&10A(3)	hrs		11,797	176,957	93	11,797	177,050	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				88,486		88,486	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	17,624	\$ 264,371	\$ 88,579	17,624	\$ 352,950	14

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

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 5,017,939	\$ 5,017,939	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	1,052,044	1,052,044	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,347	29,347	6
7	Other Prepaid Expenses	9,168	9,168	7
8	Accounts Receivable (owners or related parties)	2,057	2,057	8
9	Other(specify): Due from Related Parties	134,721	134,721	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,245,276	\$ 6,245,276	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	103,917	32,860	13
14	Buildings, at Historical Cost	528,492	557,224	14
15	Leasehold Improvements, at Historical Cost	597,621	673,746	15
16	Equipment, at Historical Cost	259,798	259,798	16
17	Accumulated Depreciation (book methods)	(254,760)	(224,227)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,235,068	\$ 1,299,401	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,480,344	\$ 7,544,677	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 513,204	\$ 513,204	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,473	131,473	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,409	11,409	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	23,985	23,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Withholdings	46,317	46,317	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 766,388	\$ 766,388	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,117,518	4,117,518	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)	\$ 4,117,518	\$ 4,117,518	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,883,906	\$ 4,883,906	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,596,438	\$ 2,660,771	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,480,344	\$ 7,544,677	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,596,930	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,596,934	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	999,504	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)	\$ 999,504	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)	\$ 2,596,438	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,328,456	1
2	Discounts and Allowances for all Levels	219,016	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,547,472	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,950	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,950	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	4,373	14
15	Telephone, Television and Radio	8,047	15
16	Rental of Facility Space		16
17	Sale of Drugs	150,612	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,210	20
21	Other Medical Services	3,020	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 168,262	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	Miscellaneous Revenue	2,134	28
28a	Transportation Revenue	1,002	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,136	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,084,820	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,173,156	31
32	Health Care	2,252,694	32
33	General Administration	875,954	33
	B. Capital Expense		
34	Ownership	421,383	34
	C. Ancillary Expense		
35	Special Cost Centers	264,674	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)*	\$ 5,085,316	40
41	Income before Income Taxes (line 30 minus line 40)**	999,504	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 999,504	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

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

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

Facility Name & ID Number Palm Terrace of Mattoon

0046037

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,301	2,301	\$ 53,511	\$ 23.26	1
2	Assistant Director of Nursing	2,477	2,477	42,782	17.27	2
3	Registered Nurses	2,312	2,316	49,968	21.58	3
4	Licensed Practical Nurses	28,207	29,215	496,871	17.01	4
5	CNAs & Orderlies	89,159	96,229	928,229	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,041	2,081	27,736	13.33	9
10	Activity Assistants	3,387	3,395	29,984	8.83	10
11	Social Service Workers	11,054	11,054	151,065	13.67	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	40,489	19.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,542	18,245	146,955	8.05	15
16	Dishwashers					16
17	Maintenance Workers	6,166	6,238	76,141	12.21	17
18	Housekeepers	25,670	26,117	188,288	7.21	18
19	Laundry	8,504	8,864	66,926	7.55	19
20	Administrator	2,088	2,088	74,771	35.81	20
21	Assistant Administrator	433	433	10,313	23.82	21
22	Other Administrative					22
23	Office Manager	2,145	2,145	28,572	13.32	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	946	946	10,457	11.05	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	4,787	5,023	75,014	14.93	33
34	TOTAL (lines 1 - 33)	211,299	221,247	\$ 2,498,072 *	\$ 11.29	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 37,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,100	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)	\$ 38,100		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	7 263	10(3)	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	7 \$ 263		53

Palm Terrace of Mattoon

0046037

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs

Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,131	3,287	59,462	18.09
Transportation	1,513	1,577	13,903	8.82
Restorative Aide	143	159	1,649	10.37
Total Line 32-Other	4,787	5,023	75,014	14.93

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	\$ 51,355	Workers' Compensation Insurance	\$ 32,016	IDPH License Fee	\$ 995		
Jamie Patton	Asst. Administrator	0	10,313	Unemployment Compensation Insurance	65,505	Advertising: Employee Recruitment	6,231		
Glenna Birch	Administrator	0	23,416	FICA Taxes	193,505	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	137,643	Patient Background Checks	235 2,350		
				Employee Meals		Misc. Dues & Subscriptions	1,183		
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	3,256		
				Employee Relations	1,432	Misc. Licenses/Permits	1,373		
				Employee Retirement	1,208	LTC Solutions License	1,600		
				Smoking Cessation	267	IHCA Dues	3,750		
						Less: Public Relations Expense	(844)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,084	TOTAL (agree to Schedule V, line 22, col.8)		\$ 431,576	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,894
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 Fees-See Page 6, Eliminated on P 3, C 7			\$ 200,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 200,000				Seminar Expense	456	
							Home Office Allocation	1,406	
C. Professional Services									
Vendor/Payee	Type		Amount						
Flynn Sales & Service	Computer Services		\$ 656						
Consolidated Communications	Computer Services		330						
RSM McGladrey	Accounting Services		9,938	N/A					
E-Health Data Solutions	Computer Services		2,902						
Heyl Royster Voelker & Allen	Legal Services		30,760						
Farnsworth Group	Architectural Services		3,497						
Misc. Vendors	Computer Services		60						
Area Wide Reporting	Legal Services		1,032						
Sarah Bush-Lincoln Health	Legal Services		240						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 49,415	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		()
							TOTAL		\$ 1,862

* Attach copy of IMRF notifications

**See instructions.

Palm Terrace of Mattoon

0046037

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		49,415

Home Office Allocation

Pearl & Associates	Legal	57
Addy Bush & Assoc	Legal	29
Registered Agent Solutions	Legal	5
Heyl, Royster, Voelker & Allen	Legal	126
Duane Morris	Legal	196
Ginoli & Co.	Accountants	6,525
RSM McGladrey	Accountants	345
McGladrey & Pullen	Accountants	526
Emdeon Business Services	Computer Services	137
Advanced Answers on Demanc	Computer Services	3,696
Access 2 Go	Computer Services	279
Ivans	Computer Services	1,208
Kemper Technology	Computer Services	579
Adminastar Federal	Computer Services	72
Logmein	Computer Services	46
E-Health Data Solutions	Computer Services	362
Miscellaneous Vendors	Computer Services	23
CDW	Computer Services	291
Miscellaneous Vendors	Professional Services	91

Total (agree to Schedule V, line 19, column 8)	<u><u>64,008</u></u>
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Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$3,750
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,829 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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.
- (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. \$ 4,373
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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 still 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees