



Facility Name & ID Number Palm Terrace of Mattoon

# 0046037 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>64,970</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>178</u>	TOTALS	<u>178</u>	<u>64,970</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>41,971</u>	<u>5,023</u>	<u>4,327</u>	<u>51,321</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,971</u>	<u>5,023</u>	<u>4,327</u>	<u>51,321</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.99%

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 3,821

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: 12/31/2009 Fiscal Year: 12/31/2009

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

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**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
	<b>A. General Services</b>										
1	Dietary	208,352	30,829		239,181		239,181	8,975	248,156		1
2	Food Purchase		313,662		313,662		313,662	(6,770)	306,892		2
3	Housekeeping	215,267	53,449		268,716		268,716	84	268,800		3
4	Laundry	70,293	25,409		95,702		95,702		95,702		4
5	Heat and Other Utilities			234,096	234,096		234,096	886	234,982		5
6	Maintenance	73,388	24,718	41,193	139,299		139,299	4,443	143,742		6
7	Other (specify):* Home Off. Ben. All.							1,621	1,621		7
8	<b>TOTAL General Services</b>	567,300	448,067	275,289	1,290,656		1,290,656	9,239	1,299,895		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	2,003,195	136,933	11,562	2,151,690		2,151,690	5,297	2,156,987		10
10a	Therapy		125	454,935	455,060		455,060		455,060		10a
11	Activities	64,034	1,345	704	66,083		66,083	(759)	65,324		11
12	Social Services	150,858	45		150,903		150,903		150,903		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							669	669		15
16	<b>TOTAL Health Care and Programs</b>	2,218,087	138,448	505,601	2,862,136		2,862,136	5,207	2,867,343		16
	<b>C. General Administration</b>										
17	Administrative	33,346		357,000	390,346		390,346	(297,665)	92,681		17
18	Directors Fees										18
19	Professional Services			25,639	25,639		25,639	33,803	59,442		19
20	Dues, Fees, Subscriptions & Promotions			8,334	8,334		8,334	5,294	13,628		20
21	Clerical & General Office Expenses	45,944	16,979	23,353	86,276		86,276	107,687	193,963		21
22	Employee Benefits & Payroll Taxes			404,277	404,277		404,277	13,173	417,450		22
23	Inservice Training & Education			598	598		598	1,309	1,907		23
24	Travel and Seminar							288	288		24
25	Other Admin. Staff Transportation			16,764	16,764		16,764	11,115	27,879		25
26	Insurance-Prop.Liab.Malpractice			74,854	74,854		74,854	1,871	76,725		26
27	Other (specify):* Home Off. Ben. All.							24,565	24,565		27
28	<b>TOTAL General Administration</b>	79,290	16,979	910,819	1,007,088		1,007,088	(98,560)	908,528		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,864,677	603,494	1,691,709	5,159,880		5,159,880	(84,114)	5,075,766		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 &amp; ID Number

Palm Terrace of Mattoon

#0046037

Report Period Beginning:

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Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			78,336	78,336		78,336	47,244	125,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			277,048	277,048		277,048	56,194	333,242			32
33	Real Estate Taxes			40,197	40,197		40,197	1,136	41,333			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,205	20,205		20,205	1,091	21,296			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			415,786	415,786		415,786	105,665	521,451			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,563		170,563		170,563		170,563			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	9,832	335	107,275	117,442		117,442	(117,442)				43
44	<b>TOTAL Special Cost Centers</b>	9,832	170,898	204,730	385,460		385,460	(117,442)	268,018			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,874,509	774,392	2,312,225	5,961,126		5,961,126	(95,891)	5,865,235			45

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



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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (7,804)	43	1
2	X-Rays-Part A	(9,061)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(135)	10	3
4	Offset Miscellaneous Food Revenue	(6,972)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(197)	21	5
6	Offset Chamber of Commerce Dues	(803)	20	6
7	Resident Flowers	(749)	43	7
8	Disallowed Special Events	(1,923)	43	8
9	Pet Expense	(1,530)	43	9
10	Offset Transportation Revenue	(759)	11	10
11	Offset of Medicare Interest Paid on Withholding	(342)	32	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	<b>Total</b>	(30,275)		49

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# 0046037

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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%	\$ 8,975	\$ 8,975	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	202	202	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	84	84	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	886	886	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,347	4,347	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,621	1,621	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,432	5,432	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	669	669	10
11	V	17 Administrative	357,000	Petersen Health Care, Inc.	100.00%	59,335	(297,665)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	12,584	12,584	12
13	V							13
14	Total		\$ 357,000			\$ 94,135	\$ * (262,865)	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%	\$ 3,507	\$ 3,507
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	91,516	91,516
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	934	934
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	288	288
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,510	4,510
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,871	1,871
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	24,565	24,565
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	7,397	7,397
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	11,377	11,377
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,136	1,136
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,087	1,087
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 148,188	\$ * 148,188

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

Facility Name &amp; ID Number

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# 0046037

Report Period Beginning:

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## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	96	96	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	21,219	21,219	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,590	2,590	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	16,368	16,368	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	13,173	13,173	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	375	375	29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	6,605	6,605	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	44,675	44,675	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	45,264	45,264	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	4	4	38	
39	Total		\$			\$ 150,369	\$ *	150,369	39

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

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# 0046037

Report Period Beginning:

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## 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	153,278	2	3.33	Salary	\$ 5,835	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	\$ 5,835		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	51,321	\$ 8,975	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	51,321	202	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	51,321	84	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	51,321	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	51,321	886	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	51,321	4,347	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	51,321	1,621	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	51,321	5,432	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	51,321	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	51,321	669	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	51,321	59,335	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	51,321	12,584	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	51,321	3,507	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	51,321	91,516	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	51,321	934	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	51,321	288	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	51,321	4,510	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	51,321	1,871	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	51,321	24,565	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	51,321	7,397	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	51,321	11,377	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	51,321	1,136	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	51,321	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	51,321	1,087	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 242,323	25

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Ending:

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VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	336,837	13		51,321		1
2	2	Food	Resident Days	336,837	13		51,321		2
3	3	Housekeeping	Resident Days	336,837	13		51,321		3
4	4	Laundry	Resident Days	336,837	13		51,321		4
5	5	Utilities	Resident Days	336,837	13		51,321		5
6	6	Maintenance	Resident Days	336,837	13	628	51,321	96	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13		51,321		7
8	10	Nursing and Medical Records	Resident Days	336,837	13		51,321		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13		51,321		9
10	17	Administrative	Resident Days	336,837	13		51,321		10
11	19	Professional Services	Resident Days	336,837	13	139,269	51,321	21,219	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001	51,321	2,590	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426	51,321	16,368	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458	51,321	13,173	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464	51,321	375	15
16	24	Travel and Seminar	Resident Days	336,837	13		51,321		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354	51,321	6,605	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13		51,321		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13		51,321		19
20	30	Depreciation	Resident Days	336,837	13	293,215	51,321	44,675	20
21	32	Interest	Resident Days	336,837	13	297,084	51,321	45,264	21
22	33	Real Estate Taxes	Resident Days	336,837	13		51,321		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13		51,321		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26	51,321	4	24
25	TOTALS					\$ 986,925	\$	\$ 150,369	25

Facility Name &amp; ID Number

Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	US Bank		X	Mortgage	\$52,952 + int.	12/31/04	\$ 4,448,000	\$ 3,848,729	12/31/11	0.0699	\$ 276,706	1								
2												2								
3							Interest Income Offset				(105)	3								
4							Home Office Allocation-PHC				11,377	4								
5							Home Office Allocation-PHC II				45,264	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 4,448,000	\$ 3,848,729			\$ 333,242	9								
<b>B. Non-Facility Related*</b>																				
10							Interest Paid on Medicare Withholding				342	10								
11							Interest Offset on Medicare Withholding Interest Paid				(342)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,448,000	\$ 3,848,729			\$ 333,242	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.)





Facility Name & ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**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	\$ 92,599	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Alzheimer's unit renovation	2003		4,026		15	268	268	1,631	9
10		Alzheimer's unit renovation	2003		26,810		15	1,787	1,787	10,872	10
11		Roof	2004		7,814		35	223	223	1,134	11
12		Boiler	2004		4,019		35	115	115	575	12
13		Alzheimer's wing renovation per cap proj	2005		312,682		30	10,423	10,423	46,903	13
14		New roof	2005		36,428		30	1,214	1,214	5,160	14
15		New flooring	2005		27,858		10	2,786	2,786	11,376	15
16		Windows	2006		3,375		25	135	135	473	16
17		Sidewalks	2006		2,980		15	199	199	696	17
18		Asphalt	2006		43,960		15	2,931	2,931	10,258	18
19		Sidewalks	2006		6,300		15	420	420	1,470	19
20		86 - Smoke	2006		7,545		7	1,078	1,078	3,773	20
21		Roof	2006		68,274		25	2,731	2,731	9,558	21
22		Tile Flooring	2006		1,648		25	66	66	231	22
23		New roof	2006		3,145		30	105	105	367	23
24		Alzheimer's wing renovation- contractors application #6	2005		39,645		30	1,322	1,322	5,949	24
25		Alzheimer's wing renovation - arch. Fees	2005		1,157		30	39	39	175	25
26		Alzheimer's wing renovation- contractors application #7	2005		4,252		30	142	142	639	26
27		Alzheimer's wing - doors and hardware	2005		1,063		30	35	35	158	27
28		Alzheimer's wing renovation- fire system	2005		1,485		30	50	50	225	28
29		Sidewalks	2007		9,988		15	666	666	1,665	29
30		Road Work	2007		3,803		15	254	254	635	30
31		Blinds	2007		2,556		10	256	256	640	31
32		Rooftop A/C Unit	2007		5,123		10	512	512	1,280	32
33		Fire Alarm	2007		5,244		10	524	524	1,310	33
34		New roof	2007		40,644		30	1,354	1,354	3,385	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Palm Terrace of Mattoon

# 0046037

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	2008	\$ 4,623	\$	5	\$ 924	\$ 924	\$ 1,386	37
38	Garage Door	2008	3,270		10	328	328	492	38
39	Water Heater	2008	4,823		5	964	964	1,446	39
40	A/C Unit-Rooftop Middle	2009	7,317		15	244	244	244	40
41	A/C Unit-Annex West	2009	7,245		15	242	242	242	41
42	Roof	2009	153,225		25	3,065	3,065	3,065	42
43	Garage	2009	21,375		20	534	534	534	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	Land Improvements Booked			5,415			(5,415)		58
59	Building Booked			13,551			(13,551)		59
60	Building Improvement Booked			31,105			(31,105)		60
61									61
62									62
63	2009-Home Office Allocation-Land Improvements		1,688			106	106		63
64	2009-Home Office Allocation-Building Improvements		25,229			605	605		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,429,111	\$ 50,071		\$ 50,198	\$ 127	\$ 220,546	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	\$ 228,317	\$ 28,327	\$ 22,832	\$ (5,495)	7-10 yrs.	\$ 109,527	71
72	Current Year Purchases	9,554	300	478	178	10 yrs.	478	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			52,072	52,072			74
75	TOTALS	\$ 237,871	\$ 28,627	\$ 75,382	\$ 46,755		\$ 110,005	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	\$	\$	\$		\$ 17,080	76
77	Facility	2003 Dodge Truck	2003	20,300					20,300	77
78										78
79										79
80	TOTALS			\$ 37,380	\$	\$	\$		\$ 37,380	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,737,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,698	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,580	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 46,882	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 367,931	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 21,296 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

**Palm Terrace of Mattoon  
0046307**

**Period Beginning 1/1/2009  
Period End 12/31/2009**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 15,533
Dishwasher	708
Maintenance Equipment	-
Copier	3,964
Home Office Allocation	1,091
	<u>21,296</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	8,236	\$ 123,545	\$	8,236	\$ 123,545	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,422	81,337		5,422	81,337	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		16,656	249,833	125	16,656	249,958	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				170,563		170,563	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10(A)3			15	220		15	220	13
14	TOTAL			\$	30,329	\$ 454,935	\$ 170,688	30,329	\$ 625,623	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: **1/1/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 6,130,414	\$ 6,130,414	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	1,034,843	1,034,843	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,578	96,578	6
7	Other Prepaid Expenses	26,521	26,521	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Due from Related Parties</b>	19,297	19,297	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 7,307,653	\$ 7,307,653	10
<b>B. Long-Term Assets</b>				
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	553,721	14
15	Leasehold Improvements, at Historical Cost	799,499	875,390	15
16	Equipment, at Historical Cost	275,251	275,251	16
17	Accumulated Depreciation (book methods)	(412,916)	(367,931)	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):	87,888	87,888	22
23	Other(specify): <b>Interco-Prairie Rose</b>	252,217	252,217	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,634,348	\$ 1,709,396	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,942,001	\$ 9,017,049	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 901,515	\$ 901,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,839	174,839	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,324	4,324	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,700	40,700	32
33	Accrued Interest Payable	24,238	24,238	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Payroll Withholdings</b>	132,214	132,214	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,277,830	\$ 1,277,830	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,848,729	3,848,729	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,848,729	\$ 3,848,729	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,126,559	\$ 5,126,559	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,815,442	\$ 3,890,490	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,942,001	\$ 9,017,049	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,151,964</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2008 Bad Debt Allowance Entered After CR Completion</b>	<b>(50,000)</b>	<b>3</b>
<b>4</b>	<b>Rounding</b>	<b>3</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,101,967</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>713,475</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>713,475</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,815,442</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 1/1/2009Ending: 12/31/2009

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,820,365	1
2	Discounts and Allowances for all Levels	(53,281)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,767,084	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	623,870	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 623,870	8
<b>C. Other Operating Revenue</b>			
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	6,972	14
15	Telephone, Television and Radio	6,588	15
16	Rental of Facility Space		16
17	Sale of Drugs	251,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,372	20
21	Other Medical Services	4,430	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 282,451	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	105	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 105	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	332	28
28a	Transportation Revenue	759	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,091	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,674,601	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,290,656	31
32	Health Care	2,862,136	32
33	General Administration	1,007,088	33
<b>B. Capital Expense</b>			
34	Ownership	415,786	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	288,005	35
36	Provider Participation Fee	97,455	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,961,126	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	713,475	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 713,475	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 part of 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:

**1/1/2009**

Ending:

**12/31/2009**

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 65,487	\$ 31.48	1
2	Assistant Director of Nursing	4,160	4,160	86,588	20.81	2
3	Registered Nurses	6,330	6,628	162,780	24.56	3
4	Licensed Practical Nurses	28,853	30,463	570,296	18.72	4
5	CNAs & Orderlies	94,528	97,332	1,006,750	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	2,060	22,971	11.15	9
10	Activity Assistants	1,702	1,751	19,634	11.21	10
11	Social Service Workers	11449	11,665	150,858	12.93	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	42,038	20.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,287	18,981	166,314	8.76	15
16	Dishwashers					16
17	Maintenance Workers	6,340	6,655	73,388	11.03	17
18	Housekeepers	26,319	26,966	215,267	7.98	18
19	Laundry	8,072	8,551	70,293	8.22	19
20	Administrator	2,080	2,080	71,000	34.13	20
21	Assistant Administrator	709	867	15,846	18.28	21
22	Other Administrative					22
23	Office Manager	3,997	4,118	45,944	11.16	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	8,946	9,167	142,555	15.55	33
34	TOTAL (lines 1 - 33)	227,888	235,604	\$ 2,928,009 *	\$ 12.43	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	38,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	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) <u>Psychologist</u>	2 Visits	175	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,775		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

Palm Terrace of Mattoon

0046307

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Restorative aide	83	83	940	11.33
Care Plan Coordinator	4,174	4,328	83,313	19.25
Marketing	727	747	9,832	13.16
Transportation	1,882	1,929	21,429	11.11
Alzheimer's Coordinator	2,080	2,080	27,041	13.00
<b>TOTAL (lines 1 - 35)</b>	<b>8,946</b>	<b>9,167</b>	<b>142,555</b>	



**Palm Terrace of Mattoon**

**0046037**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		25,639

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	81
GoffWilson, P.A.	Legal	115
Jackson Lewis	Legal	906
Peter Gartelos	Legal	88
Misc.	Legal	78
Ginoli & Company	Accountants	5,954
Miscellaneous Vendors	Computer Services	83
Emdeon Business Services	Computer Services	38
Advanced Answers on Demand	Computer Services	4,835
Access 2 Go	Computer Services	465
Ivans	Computer Services	288
Kemper Technology	Computer Services	1,314
VisionShare	Computer Services	409
MediFax	Computer Services	167
LogmIn	Computer Services	72
Charter Communications	Computer Services	3
CDW	Computer Services	733
Simple LTC	Computer Services	1,115
Polaris Group	Other Professional Services	16,024
Donna Howard & Assoc.	Other Professional Services	274
Miscellaneous Vendors	Miscellaneous	761
Total (agree to Schedule V, line 19, column 8)		<u>59,442</u>

**Palm Terrace of Mattoon**

**0046037**

**Period Beginning**

**1/1/2009**

**Period End**

**12/31/2009**

**Schedule 21B**

**XIX. SUPPORT SCHEDULE**

**Legal Fees**

**Facility**

<b>Vendor/Payee</b>	<b>Invoice Total</b>	<b>Allocation %</b>	<b>Total</b>
Heyl, Royster, Voelker, & Allen	288.80	100%	289
Heyl, Royster, Voelker, & Allen	150.50	100%	151
Brown & James	8,292.45	100%	8,292
Brown & James	2,680.75	100%	2,681
Brown & James	1,602.20	100%	1,602
Brown & James	1,913.40	100%	1,913
Heyl, Royster, Voelker, & Allen	81.00	100%	81
Heyl, Royster, Voelker, & Allen	276.00	100%	276
Tra Beicher	1,200.00	100%	1,200
Brown & James	1,493.20	100%	1,493
Heyl, Royster, Voelker, & Allen	513.72	100%	514
Heyl, Royster, Voelker, & Allen	713.34	100%	713

**Home Office Allocation**

Heyl, Royster, Voelker, and Allen	2,414.77	3.36%	81
GoffWilson	3,425.00	3.36%	115
Jackson Lewis	27,043.20	3.36%	906
Peter Gartelos	2,612.50	3.36%	88
Miscellaneous Vendors	2,327.62	3.36%	78

**Total Legal Fees**

20,473



Facility Name & ID Number Palm Terrace of Mattoon# 0046037Report Period Beginning: 1/1/2009Ending: 12/31/2009**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. 1,500 IHCA
- (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? No
- (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. \$ 11,531 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? N/A  
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. \$ 6,972
- (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. \$ No
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.