

		FOR BHF USE					

LL1

**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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

<p><b>I. IDPH License ID Number:</b> <u>0052274</u></p> <p><b>Facility Name:</b> <u>Palm Terrace of Mattoon</u></p> <p><b>Address:</b> <u>1000 Palm Avenue</u> <u>Mattoon</u> <u>61938</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Coles</u></p> <p><b>Telephone Number:</b> <u>(217) 234-7403</u> <b>Fax #</b> <u>(217) 258-6642</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>11/1/2002</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	41,130	5,344	5,061	51,535	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,130	5,344	5,061	51,535	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)

Meals on Wheels

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

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 4,101

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name &amp; ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	245,688	27,759		273,447		273,447	17,418	290,865		1
2	Food Purchase		363,311		363,311		363,311	(12,119)	351,192		2
3	Housekeeping	228,102	64,213		292,315		292,315	107	292,422		3
4	Laundry	78,734	28,924		107,658		107,658		107,658		4
5	Heat and Other Utilities			247,488	247,488		247,488	655	248,143		5
6	Maintenance	56,339	25,368	23,146	104,853		104,853	6,548	111,401		6
7	Other (specify):* Home Off. Ben. All.										7
8	<b>TOTAL General Services</b>	<b>608,863</b>	<b>509,575</b>	<b>270,634</b>	<b>1,389,072</b>		<b>1,389,072</b>	<b>12,609</b>	<b>1,401,681</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			38,400	38,400		38,400	62	38,462		9
10	Nursing and Medical Records	2,324,510	148,259	28,163	2,500,932		2,500,932	(209)	2,500,723		10
10a	Therapy		605	584,410	585,015		585,015		585,015		10a
11	Activities	87,799	10	60	87,869		87,869	(25,323)	62,546		11
12	Social Services	78,958			78,958		78,958		78,958		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,491,267</b>	<b>148,874</b>	<b>651,033</b>	<b>3,291,174</b>		<b>3,291,174</b>	<b>(25,470)</b>	<b>3,265,704</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	40,000		438,600	478,600		478,600	(383,112)	95,488		17
18	Directors Fees										18
19	Professional Services			15,306	15,306		15,306	60,109	75,415		19
20	Dues, Fees, Subscriptions & Promotions			10,833	10,833		10,833	(20)	10,813		20
21	Clerical & General Office Expenses	47,666	7,831	28,361	83,858		83,858	194,804	278,662		21
22	Employee Benefits & Payroll Taxes			462,764	462,764		462,764	41,106	503,870		22
23	Inservice Training & Education							78	78		23
24	Travel and Seminar							68	68		24
25	Other Admin. Staff Transportation			18,236	18,236		18,236	10,576	28,812		25
26	Insurance-Prop.Liab.Malpractice			52,409	52,409		52,409	64,156	116,565		26
27	Other (specify):* Home Off. Ben. All.										27
28	<b>TOTAL General Administration</b>	<b>87,666</b>	<b>7,831</b>	<b>1,026,509</b>	<b>1,122,006</b>		<b>1,122,006</b>	<b>(12,235)</b>	<b>1,109,771</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,187,796</b>	<b>666,280</b>	<b>1,948,176</b>	<b>5,802,252</b>		<b>5,802,252</b>	<b>(25,096)</b>	<b>5,777,156</b>		<b>29</b>

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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>D. Ownership</b>											
30	Depreciation			4,678	4,678	4,678	84,213	88,891				30
31	Amortization of Pre-Op. & Org.						7,026	7,026				31
32	Interest						220,077	220,077				32
33	Real Estate Taxes						43,072	43,072				33
34	Rent-Facility & Grounds			527,150	527,150	527,150	(527,150)					34
35	Rent-Equipment & Vehicles			25,037	25,037	25,037	2,577	27,614				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			556,865	556,865	556,865	(170,185)	386,680				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,647		143,647	143,647		143,647				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			409,983	409,983	409,983		409,983				42
43	Other (specify):*	30,153	965	111,255	142,373	142,373	(142,373)					43
44	<b>TOTAL Special Cost Centers</b>	30,153	144,612	521,238	696,003	696,003	(142,373)	553,630				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,217,949	810,892	3,026,279	7,055,120	7,055,120	(337,654)	6,717,466				45

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

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,033)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,167)	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	(3,057)	30		9
10	Interest and Other Investment Income	(77)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(483)	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	(66,868)	43		18
19	Entertainment				19
20	Contributions	(650)	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	1,648	43		24
25	Fund Raising, Advertising and Promotional	(11,356)	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 Page 5A	(81,539)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (184,582)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(153,072)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (153,072)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (337,654)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Palm Terrace of Mattoon

ID# 0052274

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (9,281)	43	1
2	X-Rays-Part A	(8,549)	43	2
3	Offset Transportation Revenue	(25,323)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(265)	21	4
5	Offset Chamber of Commerce Dues	(905)	20	5
6	Resident Flowers	(150)	43	6
7	Disallowed Marketing Expense	(31,118)	43	7
8	Pet Expense	(1,160)	43	8
9	Offset Nursing Supplies Revenue	(259)	10	9
10	Offset Meals on Wheels Revenue	(4,290)	2	10
11	Disallowed Special Event	(239)	43	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>		(81,539)	49

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 7,587	\$ 7,587	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	182	182	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	39	39	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	512	512	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,879	2,879	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	62	62	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2	2	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,543	6,543	12
13	V							13
14	Total		\$			\$ 17,806	\$ * 17,806	14

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



**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 364	\$	364	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	85,404		85,404	16
17	V	22 Employee Benefits & Payroll		Petersen Health Care, Inc.	100.00%	3,883		3,883	17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	43		43	18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	27		27	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,907		6,907	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,217		1,217	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,975		6,975	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,436		4,436	24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	343		343	25
26	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	1,755		1,755	26
27	V	35 Rent-Equipment & Vehicles							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	<b>Total</b>		\$			\$ 111,354	\$ *	111,354	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Management Company, Inc.	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Management Company, Inc.	100.00%	0		16
17	V	3 Housekeeping		Petersen Management Company, Inc.	100.00%	0		17
18	V	4 Laundry		Petersen Management Company, Inc.	100.00%	0		18
19	V	5 Utilities		Petersen Management Company, Inc.	100.00%	0		19
20	V	6 Maintenance		Petersen Management Company, Inc.	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, Inc.	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Management Company, Inc.	100.00%	0		22
23	V	12 Social Services		Petersen Management Company, Inc.	100.00%	0		23
24	V	17 Administrative		Petersen Management Company, Inc.	100.00%	0		24
25	V	19 Professional Services		Petersen Management Company, Inc.	100.00%	34,433	34,433	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, Inc.	100.00%	402	402	26
27	V	21 Clerical and General Office		Petersen Management Company, Inc.	100.00%	1,765	1,765	27
28	V	22 Employee Benefits & Payroll		Petersen Management Company, Inc.	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Management Company, Inc.	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Management Company, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Management Company, Inc.	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, Inc.	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Management Company, Inc.	100.00%	0		33
34	V	30 Depreciation		Petersen Management Company, Inc.	100.00%	4,433	4,433	34
35	V	32 Interest		Petersen Management Company, Inc.	100.00%	61,762	61,762	35
36	V	33 Real Estate Taxes		Petersen Management Company, Inc.	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Management Company, Inc.	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, Inc.	100.00%	0		38
39	Total		\$			\$ 102,795	\$ * 102,795	39

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

Facility Name & ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	30 Depreciation	\$	Petersen 23, LLC	100.00%	\$ 75,389	\$ 75,389
16	V	31 Amortization		Petersen 23, LLC	100.00%	7,026	7,026
17	V	32 Interest		Petersen 23, LLC	100.00%	153,329	153,329
18	V	33 Real Estate Taxes		Petersen 23, LLC	100.00%	42,464	42,464
19	V	26 Insurance		Petersen 23, LLC	100.00%	62,630	62,630
20	V	34 Rent-Facility and Grounds	527,150	Petersen 23, LLC	100.00%		(527,150)
21	V	19 Professional Fees		Petersen 23, LLC	100.00%	4,353	4,353
22	V						
23	V						
24	V						
25	V						
26	V						
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		\$ 527,150			\$ 345,191	\$ * (181,959)

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

Facility Name &amp; ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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 Management Company, Inc.		\$ 9,831	\$	9,831	15
16	V	2 Food		Petersen Management Company, Inc.		22		22	16
17	V	3 Housekeeping		Petersen Management Company, Inc.		68		68	17
18	V	5 Utilities		Petersen Management Company, Inc.		143		143	18
19	V	6 Maintenance		Petersen Management Company, Inc.		3,669		3,669	19
20	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, Inc.		0		0	20
21	V	9 Medical Director		Petersen Management Company, Inc.		0		0	21
22	V	10 Nursing and Medical Records		Petersen Management Company, Inc.		48		48	22
23	V	10A Therapy		Petersen Management Company, Inc.		0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Management Company, Inc.		0		0	24
25	V	17 Administrative	438,600	Petersen Management Company, Inc.		55,488		(383,112)	25
26	V	19 Professional Services		Petersen Management Company, Inc.		14,780		14,780	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, Inc.		119		119	27
28	V	21 Clerical and General Office		Petersen Management Company, Inc.		107,900		107,900	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Management Company, Inc.		37,223		37,223	29
30	V	23 Inservice Training & Education		Petersen Management Company, Inc.		35		35	30
31	V	24 Travel and Seminar		Petersen Management Company, Inc.		41		41	31
32	V	25 Other Admin. Staff Transport.		Petersen Management Company, Inc.		3,669		3,669	32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, Inc.		309		309	33
34	V	27 Mgmt. Allocation of Benefits		Petersen Management Company, Inc.		0		0	34
35	V	30 Depreciation		Petersen Management Company, Inc.		473		473	35
36	V	32 Interest		Petersen Management Company, Inc.		627		627	36
37	V	33 Real Estate Taxes		Petersen Management Company, Inc.		265		265	37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, Inc.		822		822	38
39	Total		\$ 438,600			\$ 235,532	\$ *	(203,068)	39

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

Facility Name & ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name &amp; ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name &amp; ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30



Facility Name & ID Number Palm Terrace of Mattoon # 0052274 Report Period Beginning: 1/1/14 Ending: 12/31/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6	N/A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	1,572,338	77	\$ 231,473	\$ 220,289	51,535	\$ 7,587	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	51,535	182	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	51,535	39	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	51,535	512	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	51,535	2,879	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	51,535	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	51,535	62	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	51,535	2	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	51,535	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	51,535	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	51,535	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	51,535	6,543	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	51,535	364	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	51,535	85,404	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	51,535	3,883	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	51,535	43	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	51,535	27	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	51,535	6,907	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	51,535	1,217	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	51,535	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	51,535	6,975	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	51,535	4,436	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	51,535	343	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	51,535	1,755	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 129,160	25

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Management Company, 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	176,988	6	\$	51,535	\$	1
2	2	Food	Resident Days	176,988	6		51,535		2
3	3	Housekeeping	Resident Days	176,988	6		51,535		3
4	4	Laundry	Resident Days	176,988	6		51,535		4
5	5	Utilities	Resident Days	176,988	6		51,535		5
6	6	Maintenance	Resident Days	176,988	6		51,535		6
7	7	Mgmt. Allocation of Benefits	Resident Days	176,988	6		51,535		7
8	10	Nursing and Medical Records	Resident Days	176,988	6		51,535		8
9	15	Mgmt. Allocation of Benefits	Resident Days	176,988	6		51,535		9
10	17	Administrative	Resident Days	176,988	6		51,535		10
11	19	Professional Services	Resident Days	176,988	6	118,256	51,535	34,433	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	176,988	6	1,380	51,535	402	12
13	21	Clerical and General Office	Resident Days	176,988	6	6,062	51,535	1,765	13
14	22	Employee Benefits & Payroll	Resident Days	176,988	6		51,535		14
15	23	Inservice Training & Education	Resident Days	176,988	6		51,535		15
16	24	Travel and Seminar	Resident Days	176,988	6		51,535		16
17	25	Other Admin. Staff Transport.	Resident Days	176,988	6		51,535		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	176,988	6		51,535		18
19	27	Mgmt. Allocation of Benefits	Resident Days	176,988	6		51,535		19
20	30	Depreciation	Resident Days	176,988	6	15,225	51,535	4,433	20
21	32	Interest	Resident Days	176,988	6	212,111	51,535	61,762	21
22	33	Real Estate Taxes	Resident Days	176,988	6		51,535		22
23	34	Rent-Facility and Grounds	Resident Days	176,988	6		51,535		23
24	35	Rent-Equipment & Vehicles	Resident Days	176,988	6		51,535		24
25	TOTALS					\$ 353,034	\$	\$ 102,795	25

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Management Company, 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	1,572,338	77	\$ 299,961	\$ 294,997	51,535	\$ 9,831	1
2	2	Food	Resident Days	1,572,338	77	675		51,535	22	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	51,535	68	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		51,535	143	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	51,535	3,669	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			51,535		6
7	9	Medical Director	Resident Days	1,572,338	77			51,535		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		51,535	48	8
9	10A	Therapy	Resident Days	1,572,338	77			51,535		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			51,535		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	51,535	55,488	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		51,535	14,780	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		51,535	119	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	51,535	107,900	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		51,535	37,223	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		51,535	35	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		51,535	41	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		51,535	3,669	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		51,535	309	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			51,535		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		51,535	473	21
22	32	Interest	Resident Days	1,572,338	77	19,133		51,535	627	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		51,535	265	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		51,535	822	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 235,532	25

Facility Name & ID Number

Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	First Merit		X	HUD Mortgage	Varies	5/1/13	4,673,000	\$ 4,479,427	4/30/38	Varies	\$ 153,329						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6																	
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$ 4,673,000	\$ 4,479,427			\$ 153,329						
<b>B. Non-Facility Related*</b>																	
10										Home Office Allocation - PHMC	627						
11										Interest Income Offset	(77)						
12										Home Office Allocation-PHC	4,436						
13										Home Office Allocation-PMC	61,762						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 66,748						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,673,000	\$ 4,479,427			\$ 220,077						

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

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.			\$	<b>42,444</b>	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.)	2013		\$	<b>41,828</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(616)</b>	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>43,080</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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.					
<b>TOTAL REFUND</b>	<b>\$</b>	<b>For</b>	<b>Tax Year.</b>	<b>Home Office Allocation</b>	<b>608</b>
				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>43,072</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>39,261</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>39,293</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>39,510</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>41,212</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>41,828</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>Accrual based on prior year tax bill.</b>					

**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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Palm Terrace of Mattoon COUNTY Coles  
 FACILITY IDPH LICENSE NUMBER 0052274  
 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-1-00908-000</u>	<u>Long-Term Care Facility</u>	\$ <u>41,827.96</u>	\$ <u>41,827.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>41,827.96</u></u>	\$ <u><u>41,827.96</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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



**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

N/A

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

1. Total Amount Incurred: 175,661 2. Number of Years Over Which it is Being Amortized: 25  
 3. Current Period Amortization: 7,026 4. Dates Incurred: May to December 2013

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	<b>TOTALS</b>	<b>44,000</b>		<b>\$ 32,860</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	178	2002	1969	\$ 528,492	\$	39	\$ 13,551	\$ 13,551	\$ 160,354	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Alzheimer's unit renovation		2003	4,026		15	268	268	2,971	9
10	Alzheimer's unit renovation		2003	26,810		15	1,787	1,787	19,807	10
11	Roof		2004	7,814		35	223	223	2,249	11
12	Boiler		2004	4,019		35	115	115	1,150	12
13	Alzheimer's wing renovation per cap proj		2005	312,682		30	10,423	10,423	99,018	13
14	New roof		2005	36,428		30	1,214	1,214	11,230	14
15	New flooring		2005	27,858		10	2,786	2,786	25,306	15
16	Windows		2006	3,375		25	135	135	1,148	16
17	Sidewalks		2006	2,980		15	199	199	1,691	17
18	Asphalt		2006	43,960		15	2,931	2,931	24,913	18
19	Sidewalks		2006	6,300		15	420	420	3,570	19
20	86 - Smoke		2006	7,545		7			7,545	20
21	Roof		2006	68,274		25	2,731	2,731	23,213	21
22	Tile Flooring		2006	1,648		25	66	66	561	22
23	New roof		2006	3,145		30	105	105	892	23
24	Alzheimer's wing renovation- contractors application #6		2005	39,645		30	1,322	1,322	12,559	24
25	Alzheimer's wing renovation - arch. Fees		2005	1,157		30	39	39	370	25
26	Alzheimer's wing renovation- contractors application #7		2005	4,252		30	142	142	1,349	26
27	Alzheimer's wing - doors and hardware		2005	1,063		30	35	35	333	27
28	Alzheimer's wing renovation- fire system		2005	1,485		30	50	50	475	28
29	Sidewalks		2007	9,988		15	666	666	4,995	29
30	Road Work		2007	3,803		15	254	254	1,905	30
31	Blinds		2007	2,556		10	256	256	1,920	31
32	Rooftop A/C Unit		2007	5,123		10	512	512	3,840	32
33	Fire Alarm		2007	5,244		10	524	524	3,930	33
34	New roof		2007	40,644		30	1,354	1,354	10,155	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

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	2008	\$ 4,623	\$	5	\$	\$	\$ 4,623	37
38	Garage Door	2008	3,270		10	328	328	2,132	38
39	Water Heater	2008	4,823		5			4,823	39
40	A/C Unit-Rooftop Middle	2009	7,317		15	488	488	2,684	40
41	A/C Unit-Annex West	2009	7,245		15	484	484	2,662	41
42	Roof	2009	153,225		25	6,130	6,130	33,715	42
43	Garage	2009	20,375		20	1,019	1,019	5,629	43
44	Sidewalk Repair	2010	2,528		7	362	362	1,629	44
45	Sidewalk Repair	2011	6,108		15	408	408	1,428	45
46	Kitchen Exhaust Fan	2011	12,461		10	1,246	1,246	4,361	46
47	Roof Replacement on South West Wing roof	2011	22,370		25	895	895	3,132	47
48	Generator	2013	17,656		15	1,178	1,178	1,767	48
49	Sprinkler System Replacement	2013	184,250		25	7,370	7,370	11,055	49
50	Parking Lot Sealcoat	2013	6,105		7	872	872	1,308	50
51	Parking Lot Repair	2014	24,325		25	405	405	405	51
52	Vinyl Plank Floor in Main Hallways	2014	19,851		15	662	662	662	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			6,183			(6,183)		63
64	Building Booked			13,551			(13,551)		64
65	Building Improvement Booked			43,992			(43,992)		65
66									66
67	2014-Home Office Allocation-Building Improvements		24,057			577	577		67
68	2014-Home Office Allocation-Land Improvements		2,246			123	123		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,723,151	\$ 63,726		\$ 64,655	\$ 929	\$ 509,464	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 110,875	\$ 14,374	\$ 11,088	\$ (3,286)	5-10 yrs.	\$ 85,205	71
72	Current Year Purchases	2,425	145	145		10 yrs.		72
73	Fully Depreciated Assets	153,457					153,457	73
74	Home Office Allocation			11,181	11,181			74
75	TOTALS	\$ 266,757	\$ 14,519	\$ 22,414	\$ 7,895		\$ 238,662	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2002 Jetta	2003	\$ 17,080	\$	\$	\$		\$ 17,080	76
77	Facility	2003 Dodge Truck	2003	20,300					20,300	77
78	Facility	1999 Ford	2010	9,112	1,822	1,822		5 yrs.	7,288	78
79										79
80	TOTALS			\$ 46,492	\$ 1,822	\$ 1,822	\$		\$ 44,668	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 2,069,260	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 80,067	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 88,891	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 8,824	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 792,794	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	Nursing Area Remodel	\$ 116,975	92
93			93
94			94
95		\$ 116,975	95

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

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

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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

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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 17,472 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250 Van	\$ 822.05	\$ 10,142	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 10,142	21

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

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

**Palm Terrace of Mattoon**

**0052274**

**Period Beginning 1/1/2014**

**Period End 12/31/2014**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$ 13,654
Dishwasher	1,025
Laundry Equipment	-
Copier	216
Home Office Allocation	<u>2,577</u>
	<u><u>17,472</u></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>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	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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A(3)	hrs	\$	13,360	\$	200,398	\$	13,360	\$	200,398	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,873		103,101		6,873		103,101	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		18,727		280,911		18,727		281,516	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39(2)	# of prescrpts						143,647		143,647	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	<b>TOTAL</b>			\$	38,960	\$	584,410	\$	144,252	\$	728,662	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 # 0052274 Report Period Beginning: 1/1/14 Ending: 12/31/14  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 362,211	\$ 362,211	1
2	Cash-Patient Deposits	6,536	6,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,326</u> )	1,112,978	1,112,978	3
4	Supply Inventory (priced at <u>Cost</u> )	26,521	26,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	62,303	78,518	6
7	Other Prepaid Expenses	158,323	158,323	7
8	Accounts Receivable (owners or related parties)		45,078	8
9	Other(specify): <u>Security Dep &amp; Ed. Loans</u>	1,987	1,987	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,730,859	\$ 1,792,152	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		32,860	13
14	Buildings, at Historical Cost		552,549	14
15	Leasehold Improvements, at Historical Cost	67,937	1,170,602	15
16	Equipment, at Historical Cost	48,917	313,249	16
17	Accumulated Depreciation (book methods)	(49,123)	(792,794)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		163,950	20
21	Restricted Funds		1,038,121	21
22	Other Long-Term Assets (spec <u>Cons. In Progress</u> )	105,388	105,388	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 173,119	\$ 2,583,925	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,903,978	\$ 4,376,077	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,126,811	\$ 1,149,949	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,816	186,816	30
31	Accrued Taxes Payable (excluding real estate taxes)	164,157	164,157	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,080	32
33	Accrued Interest Payable		12,617	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	10,022	10,022	36
37	<u>Accrued Management Fees</u>			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,487,806	\$ 1,566,641	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,479,427	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Due to Due From Intercompany</u>	2,765,122	270,303	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,765,122	\$ 4,749,730	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,252,928	\$ 6,316,371	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,348,950)	\$ (1,940,294)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,903,978	\$ 4,376,077	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (2,622,721)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>		<b>3</b>
<b>4</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>	\$ (2,622,721)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	273,771	<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>	\$ 273,771	<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>	\$ (2,348,950)	<b>24</b> *

\* 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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,506,921	1
2	Discounts and Allowances for all Levels	(518,253)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,988,668</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,063,714	6
7	Oxygen	3,358	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,067,072</b>	<b>8</b>
<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	8,033	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	217,642	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,303	20
21	Other Medical Services	5,959	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 242,937</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	77	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 77</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous & Meals on Wheels Revenue	4,814	28
28a	Transportation Revenue	25,323	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 30,137</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,328,891</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,389,072	31
32	Health Care	3,291,174	32
33	General Administration	1,122,006	33
<b>B. Capital Expense</b>			
34	Ownership	556,865	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	286,020	35
36	Provider Participation Fee	409,983	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,055,120</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>273,771</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 273,771</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,414,839	44
45	Private Pay - Net Inpatient Revenue	735,705	45
46	Medicare - Net Inpatient Revenue	761,672	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	79,856	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(3,404)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,988,668</b>	<b>49</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	1,907	\$ 70,162	\$ 36.80	1
2	Assistant Director of Nursing	3,877	97,803	24.42	2
3	Registered Nurses	13,922	380,092	24.46	3
4	Licensed Practical Nurses	21,980	466,129	19.70	4
5	CNAs & Orderlies	89,174	1,077,881	11.28	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	2,055	25,112	11.63	8
9	Activity Director	1,885	23,664	11.86	9
10	Activity Assistants	2,279	24,737	10.27	10
11	Social Service Workers	6,270	78,958	12.59	11
12	Dietician				12
13	Food Service Supervisor	3,935	73,457	17.82	13
14	Head Cook				14
15	Cook Helpers/Assistants	17,849	172,231	9.21	15
16	Dishwashers				16
17	Maintenance Workers	3,628	56,339	14.65	17
18	Housekeepers	24,141	228,102	8.93	18
19	Laundry	7,844	78,734	9.23	19
20	Administrator	2,253	55,488	24.63	20
21	Assistant Administrator	2,080	40,000	19.23	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	3,634	47,666	12.67	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	1,283	19,894	13.15	31
32	Other Health Care(specify)				32
33	Other(specify) <u>See PG20A</u>	14,443	256,988	17.22	33
34	TOTAL (lines 1 - 33)	224,439	\$ 3,273,437 *	\$ 13.71	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	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 11,046	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 49,446		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Palm Terrace of Mattoon

0052274

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,957	4,122	82,572	20.03
Transportation	3,157	3,290	39,398	11.97
Alzheimer's Coordinator	2,065	2,236	46,057	20.60
Psychology Director	3,390	3,398	58,808	17.31
Marketing	1,875	1,875	30,153	16.08
<b>TOTAL</b>	<b>14,443</b>	<b>14,921</b>	<b>256,988</b>	

**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	
Cynthia Crable	Administrator	0	\$ 48,959	Workers' Compensation Insurance	\$ 119,652	IDPH License Fee	\$ 3,550	
Jamie Wilson	Asst. Administrator	0	40,000	Unemployment Compensation Insurance	83,320	Advertising: Employee Recruitment	767	
Monica Bessinger	Administrator	0	6,529	FICA Taxes	242,477	Health Care Worker Background Check		
				Employee Health Insurance	(10,582)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	187	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	150	
				Employee Relations	27,425	Miscellaneous Dues & Subscriptions	4,488	
				Employee Retirement	472	Home Office Allocation	885	
				Home Office Allocation	41,106			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 95,488					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 438,600					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 438,600					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Illinois Secretary of State	Filing Fees		\$ 35				Out-of-State Travel	\$
Mediacom	Computer Services		2,879					
Honkamp Krueger & Co.	Accounting Services		1,600					
Sorling Northrup	Reversal of 2013 Invoice		(84)	N/A			In-State Travel	
E-Health Data Services	Computer Services		8,927					
Allscripts	Data Services		1,949				Seminar Expense	
							Home Office Allocation	68
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 15,306				TOTAL	\$ 68

\* Attach copy of IMRF notifications

\*\*See instructions.

**Palm Terrace of Mattoon**

**0052274**

**Period Beginning**

**1/1/2014**

**Period End**

**12/31/2014**

**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)		15,306
<b>Home Office Allocation-PHC, PHCM, &amp; PMC</b>		
Lexis Nexis	Legal	18
GoffWilson	Legal	1201
Illinois Secretary of State	Legal	433
Bank of America	Legal	363
Healthcare Resources International	Legal	217
Miscellaneous	Legal	47
Addy, Bush	Legal	31
Hall, Rustom, and Fritz	Legal	36
Black, Hedin, Ballard	Legal	63
SmithAmundsen	Legal	64
CliftonLarson Allen	Accountants	2555
Ginoli & Co.	Accountants	6,446
Miscellaneous	Computer Services	47
Odessian LLC	Computer Services	15
Optimizer	Computer Services	102
Allpayer Exchange	Computer Services	32
CCH	Computer Services	54
Prism Software	Computer Services	164
Macquarie Technology Services	Computer Services	142
Advanced Answers on Demand	Computer Services	7598
Stratus Networks	Computer Services	967
Kemper Technology	Computer Services	2953
AT&T	Computer Services	12
Ability Network	Computer Services	1144
Barracuda	Computer Services	261

CIAN  
Comcast  
Emdeon  
Charter Communications  
Crawford County Title Co.  
Better Banks  
David Budde  
All Scripts  
Miscellaneous  
Marotta Gund Budd Derza  
Total (agree to Schedule V, line 19, column 8)

Computer Services	311
Computer Services	79
Computer Services	202
Computer Services	12
Other Prof Fees	15
Other Prof Fees	9
Other Prof Fees	88
Other Prof Fees	60
Other Prof Fees	9
Other Prof Fees	<u>34,359</u>
	<u><u>75,415</u></u>



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Palm Terrace of Mattoon

# 0052274

Report Period Beginning: 1/1/14

Ending: 12/31/14

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-\$3,333
- (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. \$ 41,444 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. \$ 409,983  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,033
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 25,323
  - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
  - d. Have vehicle usage logs been maintained? Adquate 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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.