

Facility Name & ID Number Palm Terrace of Mattoon

0052274 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	38,390	4,941	6,734	50,065	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,390	4,941	6,734	50,065	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.06%

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

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 / /

J. Was the facility purchased or leased after January 1, 1978?
YES Date / / 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 5,071

Medicare Intermediary / /

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	245,666	35,765	2,120	283,551		283,551	9,702	293,253		1
2	Food Purchase		364,146		364,146		364,146	(6,768)	357,378		2
3	Housekeeping	245,389	50,972		296,361		296,361	76	296,437		3
4	Laundry	69,736	18,668		88,404		88,404		88,404		4
5	Heat and Other Utilities			223,992	223,992		223,992	558	224,550		5
6	Maintenance	69,816	25,933	21,835	117,584		117,584	3,848	121,432		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	630,607	495,484	247,947	1,374,038		1,374,038	7,416	1,381,454		8
	B. Health Care and Programs										
9	Medical Director			38,400	38,400		38,400		38,400		9
10	Nursing and Medical Records	2,283,687	164,902	48,639	2,497,228		2,497,228	176	2,497,404		10
10a	Therapy		91	663,130	663,221		663,221		663,221		10a
11	Activities	119,677	194	254	120,125		120,125	(17,453)	102,672		11
12	Social Services	78,420	23		78,443		78,443		78,443		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	2,481,784	165,210	750,423	3,397,417		3,397,417	(17,277)	3,380,140		16
	C. General Administration										
17	Administrative	37,732		482,600	520,332		520,332	(409,780)	110,552		17
18	Directors Fees										18
19	Professional Services			13,956	13,956		13,956	42,738	56,694		19
20	Dues, Fees, Subscriptions & Promotions			9,157	9,157		9,157	10,302	19,459		20
21	Clerical & General Office Expenses	52,176	10,003	9,817	71,996		71,996	108,563	180,559		21
22	Employee Benefits & Payroll Taxes			402,878	402,878		402,878	72,746	475,624		22
23	Inservice Training & Education							748	748		23
24	Travel and Seminar							170	170		24
25	Other Admin. Staff Transportation			21,511	21,511		21,511	7,635	29,146		25
26	Insurance-Prop.Liab.Malpractice			5,416	5,416		5,416	77,554	82,970		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	89,908	10,003	945,335	1,045,246		1,045,246	(89,324)	955,922		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,202,299	670,697	1,943,705	5,816,701		5,816,701	(99,185)	5,717,516		29

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

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

Facility Name & ID Number Palm Terrace of Mattoon

#0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,172	5,172	5,172	79,991	85,163				30
31	Amortization of Pre-Op. & Org.						12,562	12,562				31
32	Interest						191,909	191,909				32
33	Real Estate Taxes						44,157	44,157				33
34	Rent-Facility & Grounds			539,928	539,928	539,928	(539,928)					34
35	Rent-Equipment & Vehicles			36,619	36,619	36,619	1,473	38,092				35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			581,719	581,719	581,719	(209,836)	371,883				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,400		205,400	205,400		205,400				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			368,626	368,626	368,626		368,626				42
43	Other (specify):* Home Office Ben. Allocati	24,083	100	111,422	135,605	135,605	(135,605)					43
44	TOTAL Special Cost Centers	24,083	205,500	480,048	709,631	709,631	(135,605)	574,026				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,226,382	876,197	3,005,472	7,108,051	7,108,051	(444,626)	6,663,425				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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0052274

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,783)	2		4
5	Telephone, TV & Radio in Resident Rooms	(27,161)	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	(15,062)	30		9
10	Interest and Other Investment Income	(25,289)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(414)	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	(62,178)	43		18
19	Entertainment				19
20	Contributions	(450)	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				24
25	Fund Raising, Advertising and Promotional	(25,976)	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	(37,333)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (200,646)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(243,980)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (243,980)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (444,626)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Palm Terrace of Mattoon

ID# 0052274

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (11,161)	43	1
2	X-Rays-Part A	(7,167)	43	2
3	Offset Transportation Revenue	(17,453)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(214)	21	4
5	Offset Chamber of Commerce Dues	(120)	20	5
6	Resident Flowers	(36)	43	6
7	Pet Expense	(1,087)	43	7
8	Offset Nursing Supplies Revenue	(120)	10	8
9	Disallowed Special Event	25	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(37,333)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1
	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4
	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5
	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7
	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	488	488	12
	V							13
	Total		\$			\$ 488	\$ *	488 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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 131	\$	131	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,897		1,897	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 2,028	\$ *	2,028	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, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Management Company, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Management Company, LLC	100.00%	18,774	18,774	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	9,983	9,983	26
27	V	21 Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Management Company, LLC	100.00%	1,416	1,416	33
34	V	31 Amortization		Petersen Management Company, LLC	100.00%	5,536	5,536	34
35	V	32 Interest		Petersen Management Company, LLC	100.00%	68,473	68,473	35
36	V	33 Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	0		38
39	Total		\$			\$ 104,182	\$ * 104,182	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:

1/1/2015

Ending:

12/31/2015

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 Management, Inc.	100.00%	\$ 9,702	\$ 9,702
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	15	15
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	76	76
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	558	558
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	3,848	3,848
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	296	296
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	482,600	Petersen Health Care Management, Inc.	100.00%	72,820	(409,780)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	17,162	17,162
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	308	308
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	108,777	108,777
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	72,746	72,746
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	748	748
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	170	170
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	7,635	7,635
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,173	1,173
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	17,425	17,425
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	562	562
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	1,272	1,272
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,473	1,473
39	Total		\$ 482,600			\$ 316,766	\$ * (165,834)

* 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	19 Professional Fees	\$	Petersen 23, LLC	100.00%	\$ 6,314	\$ 6,314
16	V	26 Insurance-Liability		Petersen 23, LLC	100.00%	47,715	47,715
17	V	26 Insurance-Mortgage		Petersen 23, LLC	100.00%	28,666	28,666
18	V	30 Depreciation		Petersen 23, LLC	100.00%	74,315	74,315
19	V	31 Amortization		Petersen 23, LLC	100.00%	7,026	7,026
20	V	32 Interest		Petersen 23, LLC	100.00%	148,163	148,163
21	V	33 Real Estate Taxes		Petersen 23, LLC	100.00%	42,885	42,885
22	V	34 Rent-Facility and Grounds	539,928	Petersen 23, LLC	100.00%		(539,928)
23	V				100.00%		
24	V				100.00%		
25	V				100.00%		
26	V				100.00%		
27	V				100.00%		
28	V				100.00%		
29	V				100.00%		
30	V				100.00%		
31	V				100.00%		
32	V				100.00%		
33	V				100.00%		
34	V				100.00%		
35	V				100.00%		
36	V				100.00%		
37	V				100.00%		
38	V				100.00%		
39	Total		\$ 539,928			\$ 355,084	\$ * (184,844)

* 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:

1/1/2015

Ending:

12/31/2015

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 Hospitality L	Peoria	Hospitality	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	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	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 & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number Palm Terrace of Mattoon # 0052274 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	50,065	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	50,065	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	50,065	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	50,065	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	50,065	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	50,065	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	50,065	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	50,065	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	50,065	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	50,065	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	50,065	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	50,065	488	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	50,065	131	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	50,065	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	50,065	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	50,065	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	50,065	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	50,065	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	50,065	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	50,065	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	50,065	1,897	21
22	32	Interest	Resident Days	1,553,881	75	0	0	50,065	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	50,065	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	50,065	0	24
25	TOTALS					\$ 78,110	\$		\$ 2,516	25

Facility Name & ID Number Palm Terrace of Mattoon

0052274 Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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 Management Company, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309)691-8113
 Fax Number (309)691-8622

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	172,530	6		50,065		1
2	2	Food	Resident Days	172,530	6		50,065		2
3	3	Housekeeping	Resident Days	172,530	6		50,065		3
4	4	Laundry	Resident Days	172,530	6		50,065		4
5	5	Utilities	Resident Days	172,530	6		50,065		5
6	6	Maintenance	Resident Days	172,530	6		50,065		6
7	7	Mgmt. Allocation of Benefits	Resident Days	172,530	6		50,065		7
8	10	Nursing and Medical Records	Resident Days	172,530	6		50,065		8
9	15	Mgmt. Allocation of Benefits	Resident Days	172,530	6		50,065		9
10	17	Administrative	Resident Days	172,530	6		50,065		10
11	19	Professional Services	Resident Days	172,530	6	64,696	50,065	18,774	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	172,530	6	34,401	50,065	9,983	12
13	21	Clerical and General Office	Resident Days	172,530	6		50,065		13
14	22	Employee Benefits & Payroll	Resident Days	172,530	6		50,065		14
15	23	Inservice Training & Education	Resident Days	172,530	6		50,065		15
16	24	Travel and Seminar	Resident Days	172,530	6		50,065		16
17	25	Other Admin. Staff Transport.	Resident Days	172,530	6		50,065		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	172,530	6		50,065		18
19	30	Depreciation	Resident Days	172,530	6	4,880	50,065	1,416	19
20	31	Amortization	Resident Days	172,530	6	19,078	50,065	5,536	20
21	32	Interest	Resident Days	172,530	6	235,965	50,065	68,473	21
22	33	Real Estate Taxes	Resident Days	172,530	6		50,065		22
23	34	Rent-Facility and Grounds	Resident Days	172,530	6		50,065		23
24	35	Rent-Equipment & Vehicles	Resident Days	172,530	6		50,065		24
25	TOTALS					\$ 359,020	\$	\$ 104,182	25

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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	1,553,881	75	\$ 301,135	\$ 292,840	50,065	\$ 9,702	1
2	2	Food	Resident Days	1,553,881	75	480		50,065	15	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	50,065	76	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		50,065	558	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	50,065	3,848	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			50,065		6
7	9	Medical Director	Resident Days	1,553,881	75			50,065		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		50,065	296	8
9	10A	Therapy	Resident Days	1,553,881	75			50,065		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			50,065		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	50,065	72,820	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		50,065	17,162	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		50,065	308	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	50,065	108,777	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		50,065	72,746	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		50,065	748	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		50,065	170	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		50,065	7,635	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		50,065	1,173	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			50,065		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		50,065	17,425	21
22	32	Interest	Resident Days	1,553,881	75	17,439		50,065	562	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		50,065	1,272	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		50,065	1,473	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 316,766	25

Facility Name & ID Number

Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Merit		X	HUD Mortgage	Varies	5/1/13	4,673,000	\$ 4,351,732	4/30/38	Varies	\$ 149,079	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,673,000	\$ 4,351,732			\$ 149,079	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 42,830	14						
15	TOTALS (line 9+line14)						\$ 4,673,000	\$ 4,351,732			\$ 191,909	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,666 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2014 report.		\$	43,080		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.)		\$	42,345		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	(735)		3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	43,620		4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	1,272	Home Office Allocation	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	44,157		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	39,293	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	39,510	9												
	2012	41,212	10												
	2013	41,828	11												
	2014	42,345	12												
Accrual based on prior year tax bill.															

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.

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 12,562 4. Dates Incurred: May-December 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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	TOTALS	44,000		\$ 32,860	3

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 173,905	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Alzheimer's unit renovation		2003	4,026		15	268	268	3,239	9
10	Alzheimer's unit renovation		2003	26,810		15	1,787	1,787	21,594	10
11	Roof		2004	7,814		35	223	223	2,472	11
12	Boiler		2004	4,019		35	115	115	1,265	12
13	Alzheimer's wing renovation per cap proj		2005	312,682		30	10,423	10,423	109,441	13
14	New roof		2005	36,428		30	1,214	1,214	12,444	14
15	New flooring		2005	27,858		10	2,552	2,552	27,858	15
16	Windows		2006	3,375		25	135	135	1,283	16
17	Sidewalks		2006	2,980		15	199	199	1,890	17
18	Asphalt		2006	43,960		15	2,931	2,931	27,844	18
19	Sidewalks		2006	6,300		15	420	420	3,990	19
20	86 - Smoke		2006	7,545		7			7,545	20
21	Roof		2006	68,274		25	2,731	2,731	25,944	21
22	Tile Flooring		2006	1,648		25	66	66	627	22
23	New roof		2006	3,145		30	105	105	997	23
24	Alzheimer's wing renovation- contractors application #6		2005	39,645		30	1,322	1,322	13,881	24
25	Alzheimer's wing renovation - arch. Fees		2005	1,157		30	39	39	409	25
26	Alzheimer's wing renovation- contractors application #7		2005	4,252		30	142	142	1,491	26
27	Alzheimer's wing - doors and hardware		2005	1,063		30	35	35	368	27
28	Alzheimer's wing renovation- fire system		2005	1,485		30	50	50	525	28
29	Sidewalks		2007	9,988		15	666	666	5,661	29
30	Road Work		2007	3,803		15	254	254	2,159	30
31	Blinds		2007	2,556		10	256	256	2,176	31
32	Rooftop A/C Unit		2007	5,123		10	512	512	4,352	32
33	Fire Alarm		2007	5,244		10	524	524	4,454	33
34	New roof		2007	40,644		30	1,354	1,354	11,509	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 & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	10
	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	2,460	38
39	Water Heater	2008	4,823		5			4,823	39
40	A/C Unit-Rooftop Middle	2009	7,317		15	488	488	3,172	40
41	A/C Unit-Annex West	2009	7,245		15	484	484	3,146	41
42	Roof	2009	153,225		25	6,130	6,130	39,845	42
43	Garage	2009	20,375		20	1,019	1,019	6,648	43
44	Sidewalk Repair	2010	2,528		7	362	362	1,991	44
45	Sidewalk Repair	2011	6,108		15	408	408	1,836	45
46	Kitchen Exhaust Fan	2011	12,461		10	1,246	1,246	5,607	46
47	Roof Replacement on South West Wing roof	2011	22,370		25	895	895	4,027	47
48	Generator	2013	17,656		15	1,178	1,178	2,945	48
49	Sprinkler System Replacement	2013	184,250		25	7,370	7,370	18,425	49
50	Parking Lot Sealcoat	2013	6,105		7	872	872	2,180	50
51	Parking Lot Repair	2014	24,325		25	973	973	1,460	51
52	Vinyl Plank Floor in Main Hallways	2014	19,851		15	1,323	1,323	1,985	52
53	Nurse Call System Replacement	2015	19,567		7	1,398	1,398	1,398	53
54	Tiling for Activity Room, Office, Showers, Kitchen, Therapy Room	2015	204,104		15	6,804	6,804	6,804	54
55	Water Heater	2015	3,379		7	242	242	242	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			49,401			(49,401)		65
66									66
67	2015-Home Office Allocation-Building Improvements		21,906			525	525		67
68	2015-Home Office Allocation-Land Improvements		2,045			131	131		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,947,849	\$ 69,135		\$ 74,049	\$ 4,914	\$ 582,939	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	\$ 113,299	\$ 9,302	\$ 8,926	\$ (376)	5-10 yrs.	\$ 94,252	71
72	Current Year Purchases	7,282	138	364	226	10 yrs.	364	72
73	Fully Depreciated Assets	153,457					153,457	73
74	Home Office Allocation							74
75	TOTALS	\$ 274,038	\$ 9,440	\$ 9,290	\$ (150)		\$ 248,073	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	912	1,824		5 yrs.	9,112	78
79										79
80	TOTALS			\$ 46,492	\$ 912	\$ 1,824	\$		\$ 46,492	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)	\$ 2,301,239	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,487	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,163	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,764	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 877,504	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.

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 28,227 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	\$ 9,865	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 9,865	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 1/1/2015

Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 18,303
Dishwasher	1,047
Copier	7,404
Home Office Allocation	<u>1,473</u>
	<u><u>28,227</u></u>

Facility Name & ID Number Palm Terrace of Mattoon # 0052274 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	15,984	\$ 239,754	\$	15,984	\$ 239,754	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,939	104,083		6,939	104,083	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		21,286	319,293	91	21,286	319,384	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				205,400		205,400	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	44,209	\$ 663,130	\$ 205,491	44,209	\$ 868,621	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: 1/1/2015 Ending: 12/31/2015
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,137,729	\$ 1,137,729	1
2	Cash-Patient Deposits	6,536	6,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>9,124</u>)	1,446,616	1,446,616	3
4	Supply Inventory (priced at <u>Cost</u>)	26,521	26,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	55,601	71,369	6
7	Other Prepaid Expenses	213,145	213,145	7
8	Accounts Receivable (owners or related parties)		45,027	8
9	Other(specify): <u>Security Dep & Ed. Loans</u>	2,205	2,205	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,888,353	\$ 2,949,148	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		32,860	13
14	Buildings, at Historical Cost		550,398	14
15	Leasehold Improvements, at Historical Cost	46,991	1,397,451	15
16	Equipment, at Historical Cost	56,198	320,530	16
17	Accumulated Depreciation (book methods)	(54,294)	(877,504)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	129	175,790	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,737)	20
21	Restricted Funds		845,593	21
22	Other Long-Term Assets (spec <u>Cons. In Progress</u>)	105,388	105,388	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 154,412	\$ 2,531,769	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,042,765	\$ 5,480,917	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,204,089	\$ 1,233,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,228	187,228	30
31	Accrued Taxes Payable (excluding real estate taxes)	462,233	462,233	31
32	Accrued Real Estate Taxes(Sch.IX-B)		43,620	32
33	Accrued Interest Payable		12,257	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	4,322	4,322	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,857,872	\$ 1,943,392	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,351,732	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	2,848,390	263,366	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,848,390	\$ 4,615,098	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,706,262	\$ 6,558,490	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,663,497)	\$ (1,077,573)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,042,765	\$ 5,480,917	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,348,950)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Entered After Cost Report Was Filed	7,182	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,341,768)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	678,271	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 678,271	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,663,497)	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 6,799,480	1	
2	Discounts and Allowances for all Levels	(605,480)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,194,000	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,220,374	6	
7	Oxygen	3,108	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,223,482	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals	6,783	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	292,799	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	16,909	20	
21	Other Medical Services	9,273	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 325,764	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	25,289	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,289	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Transportation Revenue	17,453	28	
28a	Miscellaneous Revenue	334	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,787	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,786,322	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,374,038	31	
32	Health Care	3,397,417	32	
33	General Administration	1,045,246	33	
B. Capital Expense				
34	Ownership	581,719	34	
C. Ancillary Expense				
35	Special Cost Centers	341,005	35	
36	Provider Participation Fee	368,626	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,108,051	40	
41	Income before Income Taxes (line 30 minus line 40)**	678,271	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 678,271	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,245,602	44
45	Private Pay - Net Inpatient Revenue	718,270	45
46	Medicare - Net Inpatient Revenue	1,025,446	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	153,550	47
48	Other-(specify) <u>Insurance Net Patient Revenue & Charity Allow</u>	51,132	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,194,000	49

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

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

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

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

Facility Name & ID Number Palm Terrace of Mattoon

0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	1,806	1,886	\$ 60,101	\$ 31.87	1
2	Assistant Director of Nursing	3,657	3,797	93,835	24.71	2
3	Registered Nurses	10,964	11,989	317,006	26.44	3
4	Licensed Practical Nurses	21,528	23,236	464,149	19.98	4
5	CNAs & Orderlies	85,566	89,800	1,046,317	11.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,468	1,655	20,101	12.15	9
10	Activity Assistants	4,287	4,408	43,756	9.93	10
11	Social Service Workers	5,606	5,750	78,420	13.64	11
12	Dietician					12
13	Food Service Supervisor	3,283	3,391	58,987	17.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,208	19,037	186,679	9.81	15
16	Dishwashers					16
17	Maintenance Workers	4,421	4,525	69,816	15.43	17
18	Housekeepers	26,596	27,572	245,389	8.90	18
19	Laundry	6,897	7,423	69,736	9.39	19
20	Administrator	2,079	2,079	72,820	35.03	20
21	Assistant Administrator	1,868	1,868	37,732	20.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,700	3,824	52,176	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,196	4,475	97,714	21.84	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,919	1,919	21,291	11.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	16,451	17,097	263,018	15.38	33
34	TOTAL (lines 1 - 33)	224,500	235,731	\$ 3,299,043 *	\$ 13.99	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	40	\$ 2,120	L1, C3	35
36	Medical Director	Monthly	38,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,108	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)	40	\$ 51,628		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	239	\$ 10,923	L10, C3	50
51	Licensed Practical Nurses	169	7,561	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	408	\$ 18,484		53

Palm Terrace of Mattoon

0052274

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Restorative Salaries	4,073	4,331	54,010	12.47
Alzheimer's Coordinator	2,471	2,574	58,240	22.63
Psych. Director	4,040	4,104	70,865	17.27
Transportation	4,394	4,615	55,820	12.10
Marketing	1,473	1,473	24,083	16.35
TOTAL	<u>16,451</u>	<u>17,097</u>	<u>263,018</u>	

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	
Julie Haskins	Administrator	0	\$ 17,923	Workers' Compensation Insurance	\$ 90,856	IDPH License Fee	\$ 1,990	
Monica Bessinger	Administrator	0	54,897	Unemployment Compensation Insurance	92,467	Advertising: Employee Recruitment	1,120	
				FICA Taxes	242,350	Health Care Worker Background Check		
				Employee Health Insurance	(26,655)	(Indicate # of checks performed <u>395</u>)	4,906	
				Employee Meals		Miscellaneous Licenses & Permits	1,021	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	120	
				Employee Relations	3,171	Home Office Allocation	10,302	
				Employee Retirement	689			
				Home Office Allocation	72,746			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 72,820					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 482,600				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 482,600				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	170
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V,	
Medicaid	Legal Fees	\$ 1,076					line 24, col. 8)	
Mediacom	Computer Services	2,311						
Honkamp Krueger & Co.	Accounting Services	3,210						
Erickson, Davis, Murphy, Johnson	Legal Fees	1,295						
E-Health Data Services	Computer Services	4,851						
Allscripts	Data Services	1,213						
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 13,956					

* Attach copy of IMRF notifications

**See instructions.

Palm Terrace of Mattoon

0052274

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		13,956

Home Office Allocation

Denton's US LLP	Legal	243
Applegate and Thorne	Legal	38
Miller Hall and Triggs	Legal	37
Healthcare Resources International	Legal	200
Lexis Nexis	Legal	14
GoffWilson	Legal	1670
First Merit	Legal	250
CliftonLarson Allen	Accountants	2,606
Ginoli & Co.	Accountants	8,165
Miscellaneous	Computer Services	115
CCH	Computer Services	29
PTC Select	Computer Services	40
Advanced Answers on Demand	Computer Services	5343
Stratus Networks	Computer Services	971
Kemper Technology	Computer Services	1429
AT&T	Computer Services	12
Ability Network	Computer Services	1376
CIAN	Computer Services	968
Comcast	Computer Services	37
Emdeon	Computer Services	80
Charter Communications	Computer Services	66
Allscripts	Computer Services	1164
Allpayer Exchange	Computer Services	31
E-Health Technologies	Computer Services	21
Macquarie Technology Services	Computer Services	33

Optimizer	Other Prof Fees	94
D.J. Howard Appraisers	Other Prof Fees	85
Key Corporate Services	Other Prof Fees	284
Consolidated Land Surveying	Other Prof Fees	179
Alan Litwiller	Other Prof Fees	37
Marotta Gund Budd & Derza	Other Prof Fees	17121

Total (agree to Schedule V, line 19, column 8)		<u>56,694</u>
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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												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Palm Terrace of Mattoon# 0052274

Report Period Beginning:

1/1/2015

Ending:

12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,436 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 368,626
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. \$ 6,783
- (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. \$ 17,453
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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.