

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: <u>0039370</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>Marigold Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/11</u> to <u>9/30/12</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																
Address: <u>3240 Barney Avenue</u> <u>Pekin</u> <u>61554</u> Number City Zip Code																																		
County: <u>Tazewell</u>																																		
Telephone Number: <u>(309) 347-6514</u> Fax # <u>(309) 347-6146</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>10/26/94</u>		<table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Daniel P. Caulkins</u></td></tr><tr><td>(Title) <u>Vice-President</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>David W. White, C.P.A.</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Sikich LLP</u> <u>132 South Water Street, Suite 300, Decatur, IL 62523</u></td></tr><tr><td>(Telephone) <u>(217) 423-6000</u> Fax # <u>(217) 423-6100</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Daniel P. Caulkins</u>	(Title) <u>Vice-President</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>David W. White, C.P.A.</u> <u>Partner</u>	(Firm Name & Address) <u>Sikich LLP</u> <u>132 South Water Street, Suite 300, Decatur, IL 62523</u>	(Telephone) <u>(217) 423-6000</u> Fax # <u>(217) 423-6100</u>																						
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Type of Ownership:																																		
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY,NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☒</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☐</td><td>Corporation</td></tr><tr><td>☒</td><td>"Sub-S" Corp.</td></tr><tr><td>☐</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☒	PROPRIETARY	☐	Individual	☐	Partnership	☐	Corporation	☒	"Sub-S" Corp.	☐	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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☐	County																																	
☐	Other _____																																	
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																
Name: <u>David W. White, C.P.A.</u> Telephone Number: <u>(217) 423-6000</u>																																		
Email Address: _____																																		

Facility Name & ID Number Marigold Estates# 0039370 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,631</u>			<u>5,631</u>	13
14	TOTALS	5,631			5,631	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.42%

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

170 (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)N/AF. Does the facility maintain a daily midnight census? YesG. 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 12/1/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/1/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/12 Fiscal Year: 9/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	28,158	1,980	1,204	31,342		31,342		31,342		1
2	Food Purchase		32,033		32,033		32,033		32,033		2
3	Housekeeping	43,858	4,373		48,231		48,231		48,231		3
4	Laundry		1,398		1,398		1,398		1,398		4
5	Heat and Other Utilities			14,260	14,260		14,260		14,260		5
6	Maintenance		1,990	9,271	11,261		11,261		11,261		6
7	Other (specify):* Garbage			2,713	2,713		2,713		2,713		7
8	TOTAL General Services	72,016	41,774	27,448	141,238		141,238		141,238		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	95,973	5,320	9,101	110,394		110,394		110,394		10
10a	Therapy			2,023	2,023		2,023		2,023		10a
11	Activities	27,146	1,492		28,638		28,638		28,638		11
12	Social Services	32,890		836	33,726		33,726		33,726		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Workshop			187,113	187,113		187,113	(187,113)			15
16	TOTAL Health Care and Programs	156,009	6,812	200,273	363,094		363,094	(187,113)	175,981		16
	C. General Administration										
17	Administrative	66,693			66,693		66,693		66,693		17
18	Directors Fees										18
19	Professional Services			8,240	8,240		8,240		8,240		19
20	Dues, Fees, Subscriptions & Promotions			4,065	4,065		4,065	(688)	3,377		20
21	Clerical & General Office Expenses		4,969	5,739	10,708		10,708		10,708		21
22	Employee Benefits & Payroll Taxes			48,736	48,736		48,736	(329)	48,407		22
23	Inservice Training & Education			1,480	1,480		1,480		1,480		23
24	Travel and Seminar			601	601		601		601		24
25	Other Admin. Staff Transportation			9,043	9,043	(3,758)	5,285		5,285		25
26	Insurance-Prop.Liab.Malpractice			9,224	9,224		9,224		9,224		26
27	Other (specify):*										27
28	TOTAL General Administration	66,693	4,969	87,128	158,790	(3,758)	155,032	(1,017)	154,015		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	294,718	53,555	314,849	663,122	(3,758)	659,364	(188,130)	471,234		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,252	13,252		13,252	10,192	23,444			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,634	15,634		15,634	11,548	27,182			32
33	Real Estate Taxes			12,103	12,103		12,103		12,103			33
34	Rent-Facility & Grounds			36,996	36,996		36,996	(36,996)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			77,985	77,985		77,985	(15,256)	62,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,758	3,758		3,758			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,629	42,629		42,629		42,629			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			42,629	42,629	3,758	46,387		46,387			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	294,718	53,555	435,463	783,736		783,736	(203,386)	580,350			45

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

		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	(187,113)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				18
19	Entertainment	(329)	22		19
20	Contributions	(188)	20		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	(500)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (188,130)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(15,256)	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,256)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (203,386)		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		\$ 3,758	25	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,758		47

Marigold Estates

ID#

0039370

Report Period Beginning:

10/1/11

Ending:

9/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(187,113)	0	0	0	0	0	0	0	0	0	0	(187,113)	15
16	TOTAL Health Care and Programs	(187,113)	0	0	0	0	0	0	0	0	0	0	(187,113)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(688)	0	0	0	0	0	0	0	0	0	0	(688)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(329)	0	0	0	0	0	0	0	0	0	0	(329)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,017)	0	0	0	0	0	0	0	0	0	0	(1,017)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(188,130)	0	0	0	0	0	0	0	0	0	0	(188,130)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	10,192	0	0	0	0	0	0	0	0	0	10,192	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,548	0	0	0	0	0	0	0	0	0	11,548	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,996)	0	0	0	0	0	0	0	0	0	(36,996)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	(15,256)	0	0	0	0	0	0	0	0	0	(15,256)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(188,130)	(15,256)	0	0	0	0	0	0	0	0	0	(203,386)	45

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
Richard L. Grader	50	Carlinville Estates	Carlinville	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Emerald Estates	Canton	R&D, LLP	Decatur	Landlord
		Marigold Estates	Pekin			
		Patterson House	Sullivan			

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	30	Depreciation	\$	Two-Can, Inc.	100.00%	\$ 6,866	\$ 6,866	1
2	V	32	Interest		Two-Can, Inc.	100.00%	3,235	3,235	2
3	V	34	Rent	29,496	Two-Can, Inc.	100.00%		(29,496)	3
4	V	30	Depreciation		R&D, LLP	100.00%	3,326	3,326	4
5	V	32	Interest		R&D, LLP	100.00%	8,313	8,313	5
6	V	34	Rent	7,500	R&D, LLP	100.00%		(7,500)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 36,996			\$ 21,740	\$ * (15,256)	14

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

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	Richard L. Grader	President	Administration	50.00	See Attached	10	25.00	Wages	\$ 21,574	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	21,573	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,147		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 Marigold Estates # 0039370 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 Central Office - Patterson House, Inc.
Street Address 636 West Imboden
City / State / Zip Code Decatur, IL 62521
Phone Number (217) 422-6510
Fax Number (217) 422-6819

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Attached Schedule				\$	\$			1
2										2
3										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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Regions Bank		X	Mortgage		7/1/08	\$ 525,000	\$ 416,739	7/1/13	Variable	\$ 21,915	1	
2	Town & Country Bank		X	Vehicle Loan		11/14/11	22,500	18,105		3.9500	687	2	
3	Related Parties	X		Interest Income						0.4000	(845)	3	
4												4	
5												5	
	Working Capital												
6	Town & Country Bank		X	Working Capital		2/9/10		140,012		4.5000	5,480	6	
7	Town & Country Bank		X	Interest Income							(55)	7	
8												8	
9	TOTAL Facility Related						\$ 547,500	\$ 574,856			\$ 27,182	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 547,500	\$ 574,856			\$ 27,182	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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

	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 2011 report.	\$	9,021	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.)	\$	12,071	2		
3. Under or (over) accrual (line 2 minus line 1).	\$	3,050	3		
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	9,053	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.)	\$		6		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	12,103	7		
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	8,269	8		
	2008	8,808	9		
	2009	9,130	10		
	2010	9,432	11		
	2011	9,504	12		
Line 2, R/E taxes paid: Marigold Estates bill \$9,504 + \$2,567 (1/4) Central Office bill = \$12,071					
Line 4, R/E taxes accrual: 9/12 Marigold Estates bill \$7,128 + \$1,926 (1/4) Central Office bill = \$9,053					

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Marigold Estates

COUNTY

Tazewell

FACILITY IDPH LICENSE NUMBER

0039370

CONTACT PERSON REGARDING THIS REPORT

David W. White, C.P.A.

TELEPHONE

(217) 423-6000

FAX #:

(217) 423-6100

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	11-11-07-107-009	Sec 7 T24N R4W PT of E 1/2 NW 1/4	\$ 9,503.92	\$ 9,503.92
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 9,503.92	\$ 9,503.92

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 4,356 B. General Construction Type: Exterior Brick - Vinyl Frame Wood Number of Stories One

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).
None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>50,625</u>	<u>1993</u>	<u>\$ 18,622</u>	1
2					2
3	TOTALS	50,625		\$ 18,622	3

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	16		1993	1989	\$ 273,263	\$ 6,866	39	\$ 6,866		\$ 129,369
5										
6										
7										
8	Central Office		2005		119,594	3,326	39	3,326		11,341
	Improvement Type**									
9	Bathroom/kitchen lumber, hardware & flooring			1996	10,099	505	20	505		8,121
10	Carpet, tile, flooring			1996	6,070	156	39	156		2,503
11	Bathroom remodeling			1998	2,940	147	20	147		2,058
12	Painting and wallpaper			2002	5,534		7			5,534
13	Carpet			2004	3,797		5			3,797
14	Carpet			2005	603	29	7	29		603
15	Carpet			2005	3,445	246	7	246		3,445
16	Kitchen/bathroom lumber, drywall & flooring			2005	4,248	109	39	109		817
17	Carpet			2005	2,110	151	7	151		2,110
18	New driveway			2005	23,276	1,552	15	1,552		11,379
19	Bathroom remodeling - new plumbing, walls & floor			2007	16,852	432	39	432		2,447
20	New roof			2009	12,000	308	39	308		1,000
21	Carpet			2012	8,188	585	7	585		585
22										
23										
24										
25										
26										
27										
28										
29										
30	Central Office - track lights			2009	324	16	20	16		55
31										
32										
33										
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$492,343	\$14,428		\$14,428	\$	\$185,164	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	\$99,365	\$2,753	\$2,753	\$		\$92,047	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$99,365	\$2,753	\$2,753	\$		\$92,047	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	2011 Ford E350 Van	2011	\$34,164	\$6,263	\$6,263	\$	5	\$6,263	76
77										77
78										78
79										79
80	TOTALS			\$34,164	\$6,263	\$6,263	\$		\$6,263	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)	\$644,494	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$23,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$23,444	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$283,474	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					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)

	1	2	3	4	5	6	7	8		
	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$		\$	\$		\$	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	307,061	1,090,351	3
4	Supply Inventory (priced at)	2,314	9,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	2,069	8,276	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	350,667	1,402,668	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 662,111	\$ 2,510,498	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		276,599	14
15	Leasehold Improvements, at Historical Cost	99,486	204,222	15
16	Equipment, at Historical Cost	133,529	501,112	16
17	Accumulated Depreciation (book methods)	(142,765)	(629,705)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Loan fees, net</u>)	553	2,214	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 90,803	\$ 374,992	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 752,914	\$ 2,885,490	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,070	\$ 20,565	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	140,013	560,047	29
30	Accrued Salaries Payable	6,541	27,160	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,408	13,633	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,053	32,141	32
33	Accrued Interest Payable	428	1,710	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Cash drawn in excess of available</u>	5,235	21,389	36
37	<u>Intercompany</u>	(165,934)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,814	\$ 676,645	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	18,105	72,424	39
40	Mortgage Payable	416,739	1,666,955	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 434,844	\$ 1,739,379	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 438,658	\$ 2,416,024	46
47	TOTAL EQUITY(page 18, line 24)	\$ 314,256	\$ 469,466	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 752,914	\$ 2,885,490	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 221,242	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 221,242	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,014	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	(30,000)	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)	\$ 93,014	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)	\$ 314,256	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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 697,653	1
2	Discounts and Allowances for all Levels	(3,963)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 693,690	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,376	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,376	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	199,684	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 199,684	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 906,750	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	141,238	31
32	Health Care	363,094	32
33	General Administration	155,032	33
B. Capital Expense			
34	Ownership	77,985	34
C. Ancillary Expense			
35	Special Cost Centers	3,758	35
36	Provider Participation Fee	42,629	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 783,736	40
41	Income before Income Taxes (line 30 minus line 40)**	123,014	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 123,014	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 693,690	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 693,690	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
*** 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.

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,721	1,751	18,542	10.59	9
10	Activity Assistants	934	934	8,604	9.21	10
11	Social Service Workers	1,969	2,080	32,890	15.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,942	2,071	21,737	10.50	14
15	Cook Helpers/Assistants	690	690	6,421	9.31	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	4,540	4,665	43,858	9.40	18
19	Laundry					19
20	Administrator	451	520	15,741	30.27	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	43,147	41.49	22
23	Office Manager					23
24	Clerical	455	520	7,805	15.01	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)	9,490	9,813	95,973	9.78	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,192	24,084	\$ 294,718 *	\$ 12.24	34

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	26	\$ 1,204	1,3	35
36	Medical Director	\$100/mo	1,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	232	6,947	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2	151	10a,3	40
41	Occupational Therapy Consultant	7	516	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	567	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	15	836	12,3	45
46	Other(specify)				46
47	Psychiatrist Consultant	3	298	10a,3	47
48	Psychologist Consultant	8	492	10a,3	48
49	TOTAL (lines 35 - 48)	300	\$ 12,211		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Marigold Estates

0039370

Report Period Beginning: 10/1/11

Page 21

Ending: 9/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	50	\$ 21,574
Daniel P. Caulkins	Administrative	50	21,573
Lora A. Dillman	Administrative		15,741
Jennifer Haseley	Office Assistant		7,805
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,693

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hill & White L.L.C.	CPA	\$ 8,240
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 8,240

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 5,889	
Unemployment Compensation Insurance	3,337	
FICA Taxes	21,485	
Employee Health Insurance	10,635	
Employee Meals	1,014	
Illinois Municipal Retirement Fund (IMRF)*		
Long-Term Care Insurance	2,942	
Employee Awards	56	
Employee Medical Expenses	824	
Other Employee Expenses	2,225	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 48,407

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	1,369	
Health Care Worker Background Check (Indicate # of checks performed 8)	280	
Patient Background Checks 2	46	
Dues and Subscriptions	786	
Fees and Licenses	896	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,377

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	67
Seminar Expense	534
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 601

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT.

IL478-2471

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

(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?

(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?

(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?

5 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0
Line

(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.

(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.

\$ 42,629

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?

Yes

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?

No

Indicate the amount.
\$

(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.
\$ 3,758

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

Yes

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.
\$

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

Line 23 Inservice Training & Education

Consultants	<u>1,480</u>
	<u><u>1,480</u></u>

Line 25 Other Admin. Staff Transportation

Fuel	3,907
Mileage	4,745
Vehicle Maintenance	<u>391</u>
	9,043
Less special cost center - medically necessary transportation	<u>(3,758)</u>
	<u><u>5,285</u></u>

Patterson House, Inc.10/1/11 - 9/30/12

Carlinville EstatesEmerald EstatesMarigold Estates (# 0039370)Patterson House

Page 6, Part VII, B

The facility buildings and land are owned by a related corporation, Two-Can, Inc.
Two-Can, Inc. has the same shareholders as Patterson House, Inc.

Two-Can, Inc. has the following basis in the buildings and land:

	<u>Buildings</u>	<u>Land</u>
Carlinville Estates	274,054	18,747
Emerald Estates	273,944	18,934
Marigold Estates	273,263	18,622

Interest accrued by Two-Can, Inc. on its mortgage was as follows:

Regions Bank	12,941
--------------	--------

The interest is allocated as follows:

Carlinville Estates	3,235
Emerald Estates	3,235
Marigold Estates	3,235
Patterson House	3,236

Patterson House, Inc.10/1/11 - 9/30/12

Carlenville Estates

Emerald Estates

Marigold Esta (# 0039370)

Patterson House

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability partnership, R&D LLP.
R&D LLP has the same shareholders as Patterson House, Inc.

R&D LLP has the following basis in the building:

Carlenville Estates	119,594
Emerald Estates	119,594
Marigold Estates	119,594
Patterson House	119,594

Interest accrued by R&D LLP on its mortgage was as follows:

Regions Bank	33,249
--------------	--------

The interest is allocated as follows:

Carlenville Estates	8,312
Emerald Estates	8,312
Marigold Estates	8,313
Patterson House	8,312

Patterson House, Inc.
Carlinsville Estates
Emerald Estates
Marigold Estates
Patterson House

(# 0039370)

10/1/11 - 9/30/12

Page 7, Part VII, C

Owners' Compensation
10/1/11 - 9/30/12

	<u>Total Compensation</u>	<u>Carlinsville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>
Richard L. Grader	86,294	21,574	21,573	21,574	21,573
Daniel P. Caulkins	<u>86,294</u>	<u>21,573</u>	<u>21,574</u>	<u>21,573</u>	<u>21,574</u>
	<u>172,588</u>	<u>43,147</u>	<u>43,147</u>	<u>43,147</u>	<u>43,147</u>

Patterson House, Inc. 10/1/11 - 9/30/12
Carlinville Estates
Emerald Estates
Marigold Estates (# 0039370)
Patterson House

Owners' Compensation
10/1/11 - 9/30/12

The owners' compensation included in the cost report is compensation for the following duties:

Richard L. Grader:

- Purchasing
- Approving vendors
- Reviewing accounts receivable
- Following up on billing discrepancies
- Managing cash flow
- Negotiating with the bank
- Bookkeeping
- All financial management functions

Daniel P. Caulkins:

- Operations of the facilities
- Supervising employees
- Dealing with consultants
- Buying supplies
- Inspecting the facilities
- Locating residents
- Dealing with residents' families
- Dealing with government agencies

Both owners:

- Reviewing vendor invoices
- Paying invoices
- Dealing with local day program agencies
- Attending employee meetings
- Recruiting employees
- Dealing with employee complaints

The above duties are not all encompassing.

Patterson House, Inc.
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House

(# 0039370)

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2012
The group consists of four DD homes - All with 16 beds.
All costs of the central office and common costs are allocated 25% to each facility.

Costs for this schedule were determined by finding the sum of those costs in the general ledger which were evenly allocated among the four facilities.

	Total	Carlinville	Emerald	Marigold	Patterson	Line
	Expense	25%	25%	25%	House	Ref
					25%	
Dietary Supplies	246	62	62	61	61	1
Food costs	1,418	354	354	355	355	1
Housekeeping Supplies	318	80	80	79	79	3
Utilities	12,393	3,098	3,098	3,098	3,099	5
Maintenance	7,289	1,822	1,822	1,823	1,822	6
Administrative Salaries	266,771	66,693	66,693	66,693	66,692	17
Professional Services	26,960	6,740	6,740	6,740	6,740	19
Dues, Fees and Subscriptions	4,666	1,167	1,167	1,166	1,166	20
Contributions	750	187	187	188	188	20
Office Supplies	2,834	708	708	709	709	21
Other Office Expense	4,056	1,014	1,014	1,014	1,014	21
Postage	4,767	1,192	1,192	1,191	1,192	21
Telephone	14,492	3,623	3,623	3,623	3,623	21
Payroll Taxes	19,446	4,862	4,862	4,861	4,861	22
Group Health Insurance	42,419	10,605	10,604	10,605	10,605	22
Long-Term Care Insurance	11,769	2,942	2,942	2,942	2,943	22
Workers Comp Insurance	23,556	5,889	5,889	5,889	5,889	22
Business Meals	3,499	875	875	875	874	22
Entertainment	1,317	329	330	329	329	22
Other Employee Benefits	8,086	2,021	2,021	2,022	2,022	22
Inservice Training & Education	3,038	760	760	759	759	23
Travel and seminars	2,482	620	620	621	621	24
Other Admin/Staff Transportation	13,944	3,486	3,486	3,486	3,486	25
Insurance	36,897	9,225	9,224	9,224	9,224	26
Depreciation	7,455	1,863	1,864	1,864	1,864	30

Interest Expense	62,533	15,633	15,633	15,634	15,633	32
Real Estate Taxes	10,345	2,586	2,586	2,586	2,587	33
Lease - Central Office	30,000	7,500	7,500	7,500	7,500	34
	<u>623,746</u>	<u>155,936</u>	<u>155,936</u>	<u>155,937</u>	<u>155,937</u>	

Patterson House, Inc.
 Carlinville Estates
 Emerald Estates
 Marigold Estates
 Patterson House

(# 0039370)

10/1/11 - 9/30/12

Page 9, Part IX

Mortgage

The mortgage dated 7/1/08 at Regions Bank is allocated as follows:

Regions Bank - balance @ 9/30/12

1,666,955

Carlinville Estates	416,739
Emerald Estates	416,739
Marigold Estates	416,739
Patterson House	416,738

Marigold Estates (# 0039370)

10/1/11 - 9/30/12

Page 19, Part XVII

Line 21 Other Medical Services

HAB Aid training reimbursement	<u>13,376</u>
--------------------------------	---------------

Line 28 Other Revenue

Earning Credits	8,813
Reimburse residents' travel	3,758
Workshop	<u>187,113</u>
	<u>199,684</u>

Facility fiscal year end is 9/30/12, tax year end is 12/31/12. Taxable income will not agree.

Marigold Estates (# 0039370)

10/1/11 - 9/30/12

Page 23, Part XX, Line 12

Individual employees may work in several different departments. An individual employee's wages are allocated to the specific departments based on the hours worked in those departments.

