

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0039354</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Emerald Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/15</u> to <u>9/30/16</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>1577 E Myrtle Bx 232</u> <u>Canton</u> <u>61520</u>			
Number City Zip Code			
County: <u>Fulton</u>			
Telephone Number: <u>(309) 647-6604</u> Fax # <u>(309) 647-0440</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>10/26/94</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>David W. White</u>			
Telephone Number: <u>217-423-6000</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Richard L. Grader</u>	
		(Title) <u>President</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) <u>David W. White, C.P.A</u> <u>Partner</u>	
		(Firm Name & Address) <u>Sikich LLP</u> <u>132 S. Water St, Ste. 300, Decatur, IL 62523</u>	
		(Telephone) <u>217 423-6000</u> Fax # <u>217-423-6100</u>	
		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	

Facility Name & ID Number Emerald Estates

0039354 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	5,384			5,384	13
14	TOTALS	5,384			5,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.94%

D. How many bed-hold days during this year were paid by the Department? 136 (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/A

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 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/01/93 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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 9/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/15 Ending: 9/30/16
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	24,189	2,205	1,482	27,876		27,876		27,876			1
2	Food Purchase		35,541		35,541		35,541		35,541			2
3	Housekeeping	39,898	1,493		41,391		41,391		41,391			3
4	Laundry		2,059		2,059		2,059		2,059			4
5	Heat and Other Utilities			21,398	21,398		21,398		21,398			5
6	Maintenance		1,971	16,795	18,766		18,766		18,766			6
7	Other (specify):*											7
8	TOTAL General Services	64,087	43,269	39,675	147,031		147,031		147,031			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	107,216	6,421	12,630	126,267		126,267		126,267			10
10a	Therapy			1,372	1,372		1,372		1,372			10a
11	Activities	28,998	1,632		30,630		30,630		30,630			11
12	Social Services	37,911		1,160	39,071		39,071		39,071			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			200,135	200,135		200,135	(200,135)				15
16	TOTAL Health Care and Programs	174,125	8,053	216,497	398,675		398,675	(200,135)	198,540			16
	C. General Administration											
17	Administrative	39,273			39,273		39,273		39,273			17
18	Directors Fees											18
19	Professional Services			9,942	9,942		9,942	(2,870)	7,072			19
20	Dues, Fees, Subscriptions & Promotions			1,713	1,713		1,713	(278)	1,435			20
21	Clerical & General Office Expenses		6,137	6,616	12,753		12,753		12,753			21
22	Employee Benefits & Payroll Taxes			37,606	37,606		37,606	(72)	37,534			22
23	Inservice Training & Education			1,009	1,009		1,009		1,009			23
24	Travel and Seminar			36	36		36		36			24
25	Other Admin. Staff Transportation			9,072	9,072	(1,566)	7,506		7,506			25
26	Insurance-Prop.Liab.Malpractice			3,707	3,707		3,707		3,707			26
27	Other (specify):*											27
28	TOTAL General Administration	39,273	6,137	69,701	115,111	(1,566)	113,545	(3,220)	110,325			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	277,485	57,459	325,873	660,817	(1,566)	659,251	(203,355)	455,896			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			14,932	14,932		14,932	9,163	24,095			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,983	4,983		4,983	3,356	8,339			32
33	Real Estate Taxes			13,784	13,784		13,784		13,784			33
34	Rent-Facility & Grounds			33,696	33,696		33,696	(33,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			662	662		662	(549)	113			36
37	TOTAL Ownership			68,057	68,057		68,057	(21,726)	46,331			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,566	1,566		1,566			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,766	37,766		37,766	(468)	37,298			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,766	37,766	1,566	39,332	(468)	38,864			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	277,485	57,459	431,696	766,640		766,640	(225,549)	541,091			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(200,135)	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	(93)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(468)	42		18
19	Entertainment	(72)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,870)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(185)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(549)	36		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)	\$ (204,372)		\$	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 Amount	2 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)	(21,177)	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,177)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (225,549)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		\$ 1,566	25	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)			\$ 1,566		47

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 Emerald Estates # 0039354 Report Period Beginning: 10/1/15 Ending: 9/30/16

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):*	(200,135)	0	0	0	0	0	0	0	0	0	0	(200,135)	15
16	TOTAL Health Care and Programs	(200,135)	0	0	0	0	0	0	0	0	0	0	(200,135)	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	(2,870)	0	0	0	0	0	0	0	0	0	0	(2,870)	19
20	Fees, Subscriptions & Promotions	(278)	0	0	0	0	0	0	0	0	0	0	(278)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(72)	0	0	0	0	0	0	0	0	0	0	(72)	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	(3,220)	0	0	0	0	0	0	0	0	0	0	(3,220)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(203,355)	0	0	0	0	0	0	0	0	0	0	(203,355)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	9,163	0	0	0	0	0	0	0	0	0	9,163	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	3,356	0	0	0	0	0	0	0	0	0	3,356	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(33,696)	0	0	0	0	0	0	0	0	0	(33,696)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(549)	0	0	0	0	0	0	0	0	0	0	(549)	36
37	TOTAL Ownership	(549)	(21,177)	0	0	0	0	0	0	0	0	0	(21,726)	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	(468)	0	0	0	0	0	0	0	0	0	0	(468)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(468)	0	0	0	0	0	0	0	0	0	0	(468)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(204,372)	(21,177)	0	0	0	0	0	0	0	0	0	(225,549)	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	100	Carlinville Estates	Carlinville	Two-Can, Inc.	Decatur	Landlord
		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%	\$ 6,970	\$ 6,970	1
2	V	32	Interest		Two-Can, Inc	100.00%	931	931	2
3	V	34	Rent	29,496	Two-Can, Inc	100.00%		(29,496)	3
4	V	30	Depreciation		R&D LLP	100.00%	2,193	2,193	4
5	V	32	Interest		R&D LLP	100.00%	2,425	2,425	5
6	V	34	Rent	4,200	R&D LLP	100.00%		(4,200)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 33,696			\$ 12,519	\$ * (21,177)	14

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

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								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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	100.00	See attached	10	20.00	Wages	\$ 12,689	17,1	1
2	Daniel P. Caulkins	Vice President	Administration		See attached	10	20.00	Wages	12,689	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	\$ 25,378		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

Ending: 9/30/16

(217) 422-6819

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	Town & Country Bank		X	Mortgage - refinanced		7/1/13	\$ 306,000	\$	9/16/16	3.5000	\$ 7,492	1	
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500		11/14/15	3.9500	10	2	
3	Related Parties	X		Interest income						0.2200	(363)	3	
4	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	389,200	389,200	9/16/19	3.6500		4	
5												5	
	Working Capital												
6	Town & Country Bank		X	Working Capital		2/9/10	98,000			4.5000	1,205	6	
7	Town & Country Bank		X	Interest Income							(5)	7	
8	Hickory Point Bank		X	Working Capital		9/16/16	98,000	98,000		3.5000		8	
9	TOTAL Facility Related						\$ 913,700	\$ 487,200			\$ 8,339	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 913,700	\$ 487,200			\$ 8,339	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	10,452	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.)				\$	13,276	2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,824	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	10,960	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.				\$	13,784	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	10,649	8		
		2012	10,811	9		
		2013	11,125	10		
		2014	11,207	11		
		2015	11,801	12		
Line 2, R/E taxes paid: Emerald Estates bill \$11,801 + \$1,475 Central Office bill = \$13,276				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13	
Line 4, R/E tax accrual: 9/12 Emerald Estates bill \$8,850 + Central Office bill \$2,110 = \$10,960				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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Estates COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0039354

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 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-08-25-102-007	Sect/Lot: 09 Village Square Sub	\$ 431.28	\$ 431.28
2. 09-08-25-102-009	Sect/Lot: 07 Village Square Sub	\$ 10,937.94	\$ 10,937.94
3. 09-08-25-12-008	Sect/Lot: 08 Village Square Sub	\$ 431.28	\$ 431.28
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 11,800.50	\$ 11,800.50

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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).

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	Facility	29,642	1993	\$ 18,934	1
2					2
3	TOTALS	29,642		\$ 18,934	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	\$ 273,944	\$	39	\$ 6,970	\$ 6,970	\$ 155,757
5										
6										
7										
8	Central Office		2005		79,729		39	2,193	2,193	18,918
	Improvement Type**									
9	Remodeling, flooring		1996		10,099	463	20	463		10,099
10	Remodeling, flooring		1996		6,110	157	20	157		3,146
11	Driveway		1999		11,000		20			11,000
12	Water Heater		2001		2,000		39			2,000
13	Carpet		2004		3,007		7			3,007
14	New sinks and faucets		2004		1,190		20			1,190
15	Bathroom remodeling - new plumbing, flooring, walls		2006		12,862	330	7	330		3,243
16	Bathroom remodeling - new plumbing, flooring, walls		2007		6,708	172	7	172		1,605
17	Carpet - Entire facility		2012		8,188	1,170	5	1,170		5,264
18	Roof		2013		20,197	518	39	518		1,510
19	Ramp, deck, sidewalk		2014		3,819	98	39	98		204
20	Shower unit with grab bars, new pedestal lavatory, faucet, drain.		2016		3,260	49	39	49		49
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31	Central office - track lights & receptacles		2009		216	9	20	9		67
32	New roof		2012		3,133	67	39	67		259
33	Permanent landscaping		2015		1,204	101	10	101		110
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

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 446,666	\$ 3,134		\$ 12,297	\$ 9,163	\$ 217,428	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	\$94,095	\$4,914	\$4,914	\$	Varies	\$85,238	71
72	Current Year Purchases	1,079	51	51		Varies	51	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$95,174	\$4,965	\$4,965	\$		\$85,289	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	\$6,833	\$6,833	\$	5	\$33,594	76
77										77
78										78
79										79
80	TOTALS			\$34,164	\$6,833	\$6,833	\$		\$33,594	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$594,938	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$14,932	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$24,095	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,163	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$336,311	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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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

* 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

ALLOCATION OF COSTS (d)

		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)	\$			

(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.

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	

(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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 57,740	\$ 412,367	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	46,694	341,869	3
4	Supply Inventory (priced at cost)	1,481	6,690	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,146	22,469	7
8	Accounts Receivable (owners or related parties)	388,774	2,776,956	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 497,835	\$ 3,560,350	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		291,187	14
15	Leasehold Improvements, at Historical Cost	92,993	276,938	15
16	Equipment, at Historical Cost	129,337	615,094	16
17	Accumulated Depreciation (book methods)	(161,637)	(845,678)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,693	\$ 358,091	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 558,528	\$ 3,918,441	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,308	\$ 128,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,951	53,250	30
31	Accrued Taxes Payable (excluding real estate taxes)	353	2,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,960	38,147	32
33	Accrued Interest Payable	552	3,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	945,989		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 978,113	\$ 226,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,586	39
40	Mortgage Payable	487,200	3,480,000	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)	\$ 487,200	\$ 3,491,586	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,465,313	\$ 3,718,134	46
47	TOTAL EQUITY(page 18, line 24)	\$ (906,785)	\$ 200,307	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 558,528	\$ 3,918,441	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (858,699)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (858,699)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,816	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	(83,902)	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)	\$ (48,086)	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)	\$ (906,785)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning: 10/1/15

Ending:

9/30/16

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	\$ 581,798	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 581,798	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	16,403	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,403	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	204,255	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 204,255	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 802,456	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	147,031	31
32	Health Care	398,675	32
33	General Administration	113,545	33
	B. Capital Expense		
34	Ownership	68,057	34
	C. Ancillary Expense		
35	Special Cost Centers	1,566	35
36	Provider Participation Fee	37,766	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 766,640	40
41	Income before Income Taxes (line 30 minus line 40)**	35,816	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,816	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 581,798	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)	\$ 581,798	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	849	920	9,272	10.08	9
10	Activity Assistants	1,968	1,993	19,726	9.90	10
11	Social Service Workers	2,241	2,245	37,911	16.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,397	1,475	16,393	11.11	14
15	Cook Helpers/Assistants	798	798	7,796	9.77	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,955	4,158	39,898	9.60	18
19	Laundry					19
20	Administrator	237	291	4,885	16.79	20
21	Assistant Administrator					21
22	Other Administrative	538	582	25,378	43.60	22
23	Office Manager					23
24	Clerical	267	291	9,010	30.96	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)	10,191	10,534	107,216	10.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,441	23,287	\$ 277,485 *	\$ 11.92	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	30	\$ 1,482	1,3	35
36	Medical Director	\$100/mo	1,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	293	11,140	10,3	38
39	Pharmacist Consultant				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	15	1,160	12	45
46	Other(specify)				46
47	Psychologist Consultant	17	1,351	10a,3	47
48	Psychiatrist Consultant	1	21	10a,3	48
49	TOTAL (lines 35 - 48)	356	\$ 16,354		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 NumberEmerald Estates

0039354

Report Period Beginning:10/1/15

Page 21

Ending:9/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	100	\$ 12,689
Daniel P. Caulkins	Administrative		12,689
Lora A. Dillman	Administrative		9,010
Jennifer Haseley	Office Assistant		4,885
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 39,273

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
Featherstun, Postlewait et al	Legal	\$ 2,322
Sikich	CPA	7,080
Troy Chisum	CPR instruction	540
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 9,942

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 2,961	
Unemployment Compensation Insurance	2,310	
FICA Taxes	20,610	
Employee Health Insurance	7,610	
Employee Meals	258	
Illinois Municipal Retirement Fund (IMRF)*		
Long Term Care Insurance	954	
Other Employee Expenses	2,831	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 37,534

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	287	
Health Care Worker Background Check (Indicate # of checks performed 4)		
Patient Background Checks 2		
Dues and subscriptions	545	
Fees and licenses	603	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,435

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	36
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 36

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0039354

Report Period Beginning:

10/1/15

Ending:

Page 22

9/30/16

- (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?
If YES, give association name and amount. No
- (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?
What was the average life used for new equipment added during this period? Yes
7 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. \$ 37,298
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. \$ 1,566
- 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 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Page 4, Part V

Line 36 - Other

IL replacement tax	549
Miscellaneous	113
Total, Line 36 - Other, Column 3	662

Patterson House, Inc.		
Carlinville Estates		
Emerald Estates	(#0039354)	10/1/15 - 9/30/16
Marigold Estates		
Patterson House		

Page 6, Part VII, Table 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:

Town & Country Bank	5,849
---------------------	-------

The interest is allocated as follows:

Carlinville Estates	1,595
Emerald Estates	931
Marigold Estates	1,595
Patterson House	<u>1,728</u>
	<u><u>5,849</u></u>

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

10/1/15 - 9/30/16

(#0039354)

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:

Carlinville Estates	79,729
Emerald Estates	79,729
Marigold Estates	79,729
Patterson House	79,729

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

Town & Country Bank	<u>15,240</u>
---------------------	---------------

The interest is allocated as follows:

Carlinville Estates	4,156
Emerald Estates	2,425
Marigold Estates	4,157
Patterson House	<u>4,503</u>
	<u><u>15,240</u></u>

Patterson House, Inc.
Carlinville Estates
Emerald Estates (#0039354)
Marigold Estates
Patterson House

10/1/15 - 9/30/16

Page 7, Part VII, C

Owners' Compensation
10/1/15 - 9/30/16

	<u>Total Compensation</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>	<u>Elin House (CILA)</u>	<u>Greykin House (CILA)</u>
Richard L. Grader	91,459	21,752	12,688	21,753	23,565	5,020	6,591
Daniel P. Caulkins**	<u>91,459</u>	<u>21,752</u>	<u>12,689</u>	<u>21,752</u>	<u>23,565</u>	<u>5,020</u>	<u>6,591</u>
	<u>182,917</u>	<u>43,504</u>	<u>25,377</u>	<u>43,505</u>	<u>47,131</u>	<u>10,041</u>	<u>13,183</u>

** Daniel P. Caulkins was 50% owner through 9/16/16. This compensation was paid while he was 50% owner.
Richard Grader became 100% owner on 9/16/16.

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

(#0039354)

10/1/15 - 9/30/16

Owners' Compensation
10/1/15 - 9/30/16

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

Richard L. Grader:	Daniel P. Caulkins:	Both owners:
Purchasing	Operations of the facilities	Reviewing vendor invoices
Approving vendors	Supervising employees	Paying invoices
Reviewing accounts receivable	Dealing with consultants	Dealing with local day program agencies
Following up on billing discrepancies	Buying supplies	Attending employee meetings
Managing cash flow	Inspecting the facilities	Recruiting employees
Negotiating with the bank	Locating residents	Dealing with employee complaints
Bookkeeping	Dealing with residents' families	
All financial management functions	Dealing with government agencies	

The above duties are not all encompassing.

Patterson House, Inc.
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2016
The group consists of four DD homes (16 beds each) and two CILA homes (10 beds)
Costs of the central office and common costs are allocated as follows:
Carlinville - 24%, Emerald - 14%, Marigold - 24%, Patterson - 26%, CILA's - 12%

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

	Total Expense	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	CILA Homes	Line Ref
Food costs	934	224	131	224	243	112	1
Housekeeping Supplies	135	32	19	32	35	16	3
Utilities	11,876	2,850	1,663	2,850	3,088	1,425	5
Maintenance	8,564	2,055	1,199	2,055	2,227	1,028	6
Nondepreciable equipment (consumable items)		0	0	0	0	0	7
Nursing Consultant fees	235	56	33	56	61	28	10
Administrative Salaries	217,598	52,223	30,464	52,223	56,575	26,112	17
Professional Services	59,359	15,338	9,942	15,338	16,525	2,216	19
Dues, Fees and Subscriptions	2,209	530	309	530	574	265	20
Contributions	0	0	0	0	0	0	20
Office Supplies	3,618	868	506	868	941	434	21
Other Office Expense	15,263	3,663	2,137	3,663	3,968	1,832	21
Postage	4,534	1,088	635	1,088	1,179	544	21
Telephone	11,504	2,761	1,611	2,761	2,991	1,380	21
Payroll Taxes	18,901	4,536	2,646	4,536	4,914	2,268	22
Group Health Insurance	117,220	28,133	16,411	28,133	30,477	14,066	22
Long-Term Care Insurance	6,811	1,635	954	1,635	1,771	817	22
Workers Comp Insurance	21,147	5,075	2,961	5,075	5,498	2,538	22
Business Meals	341	82	48	82	89	41	22
Entertainment	516	124	72	124	134	62	22
Other Employee Benefits	8,688	2,085	1,216	2,085	2,259	1,043	22
Inservice Training & Education	1,370	329	192	329	356	164	23
Travel and seminars	125	30	18	30	33	15	24
Other Admin/Staff Transportation	30,181	7,244	4,225	7,244	7,847	3,622	25
Insurance	26,477	6,354	3,707	6,354	6,884	3,177	26
Depreciation	4,148	995	581	995	1,078	498	30
Interest Expense	35,666	8,560	4,993	8,560	9,273	4,280	32
Real Estate Taxes	10,987	2,637	1,538	2,637	2,857	1,318	33
Lease - Central Office	34,000	8,160	4,760	8,160	8,840	4,080	34
IL replacement tax	3,923	942	549	942	1,020	471	36
	<u>656,332</u>	<u>158,612</u>	<u>93,518</u>	<u>158,612</u>	<u>171,738</u>	<u>73,853</u>	

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

10/1/15 - 9/30/16

(# 0039354)

Page 9, Part IX

Mortgage

The mortgage dated 9/16/16 at Hickory Point Bank is allocated as follows:

Balance @ 9/30/16

2,780,000

Carlinville Estates	667,200
Emerald Estates	389,200
Marigold Estates	667,200
Patterson House	722,800

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>16,403</u>
--------------------------------	---------------

Line 28, Other Revenue

Earning Credits	2,358
Residents' travel reimbursement	1,566
Gain on asset disposal	180
Miscellaneous income	16
Workshop	<u>200,135</u>
	204,255

**Facility fiscal year end is 9/30/16, tax year end is 12/31/16.
Taxable income will not agree.

Page 22, 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.