

		FOR BHF USE					

LL1

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>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>10/1/15</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>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>			
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 Marigold Estates

0039370 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	5,490			5,490	13
14	TOTALS	5,490			5,490	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.75%

D. How many bed-hold days during this year were paid by the Department? 0 (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 Marigold Estates # 0039370 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	30,184	3,419	1,393	34,996		34,996		34,996			1
2	Food Purchase		30,375		30,375		30,375		30,375			2
3	Housekeeping	41,840	4,289		46,129		46,129		46,129			3
4	Laundry		931		931		931		931			4
5	Heat and Other Utilities			21,821	21,821		21,821		21,821			5
6	Maintenance		2,685	10,896	13,581		13,581		13,581			6
7	Other (specify):*											7
8	TOTAL General Services	72,024	41,699	34,110	147,833		147,833		147,833			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	109,329	6,656	10,737	126,722		126,722		126,722			10
10a	Therapy			1,597	1,597		1,597		1,597			10a
11	Activities	24,742	1,937		26,679		26,679		26,679			11
12	Social Services	40,197		915	41,112		41,112		41,112			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			189,713	189,713		189,713	(189,713)				15
16	TOTAL Health Care and Programs	174,268	8,593	204,162	387,023		387,023	(189,713)	197,310			16
	C. General Administration											
17	Administrative	67,325			67,325		67,325		67,325			17
18	Directors Fees											18
19	Professional Services			15,338	15,338		15,338	(4,920)	10,418			19
20	Dues, Fees, Subscriptions & Promotions			2,017	2,017		2,017	(201)	1,816			20
21	Clerical & General Office Expenses		6,320	8,143	14,463		14,463		14,463			21
22	Employee Benefits & Payroll Taxes			52,260	52,260		52,260	(123)	52,137			22
23	Inservice Training & Education			479	479		479		479			23
24	Travel and Seminar			247	247		247		247			24
25	Other Admin. Staff Transportation			13,650	13,650	(469)	13,181		13,181			25
26	Insurance-Prop.Liab.Malpractice			6,354	6,354		6,354		6,354			26
27	Other (specify):*											27
28	TOTAL General Administration	67,325	6,320	98,488	172,133	(469)	171,664	(5,244)	166,420			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	313,617	56,612	336,760	706,989	(469)	706,520	(194,957)	511,563			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			14,004	14,004		14,004	9,059	23,063			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,544	8,544		8,544	5,751	14,295			32
33	Real Estate Taxes			13,294	13,294		13,294		13,294			33
34	Rent-Facility & Grounds			36,696	36,696		36,696	(36,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			942	942		942	(942)				36
37	TOTAL Ownership			73,480	73,480		73,480	(22,828)	50,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					469	469		469			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,513	39,513		39,513	(487)	39,026			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			39,513	39,513	469	39,982	(487)	39,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	313,617	56,612	449,753	819,982		819,982	(218,272)	601,710			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	(189,713)	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	(160)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(487)	42		18
19	Entertainment	(123)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,920)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(41)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(942)	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)	\$ (196,386)		\$	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)	(21,886)	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,886)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (218,272)		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		\$ 469	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			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 469		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 Marigold Estates # 0039370 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):*	(189,713)	0	0	0	0	0	0	0	0	0	0	(189,713)	15
16	TOTAL Health Care and Programs	(189,713)	0	0	0	0	0	0	0	0	0	0	(189,713)	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	(4,920)	0	0	0	0	0	0	0	0	0	0	(4,920)	19
20	Fees, Subscriptions & Promotions	(201)	0	0	0	0	0	0	0	0	0	0	(201)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(123)	0	0	0	0	0	0	0	0	0	0	(123)	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	(5,244)	0	0	0	0	0	0	0	0	0	0	(5,244)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(194,957)	0	0	0	0	0	0	0	0	0	0	(194,957)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marigold Estates # 0039370 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	9,059	0	0	0	0	0	0	0	0	0	9,059	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	5,751	0	0	0	0	0	0	0	0	0	5,751	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,696)	0	0	0	0	0	0	0	0	0	(36,696)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(942)	0	0	0	0	0	0	0	0	0	0	(942)	36
37	TOTAL Ownership	(942)	(21,886)	0	0	0	0	0	0	0	0	0	(22,828)	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	(487)	0	0	0	0	0	0	0	0	0	0	(487)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(487)	0	0	0	0	0	0	0	0	0	0	(487)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,386)	(21,886)	0	0	0	0	0	0	0	0	0	(218,272)	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%	\$ 6,866	\$ 6,866	1
2	V	32	Interest		Two-Can, Inc	100.00%	1,595	1,595	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%	4,156	4,156	5
6	V	34	Rent	7,200	R&D LLP	100.00%		(7,200)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 36,696			\$ 14,810	\$ * (21,886)	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 Marigold Estates # 0039370 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	\$ 21,753	17,1	1
2	Daniel P. Caulkins	Vice President	Administration		See attached	10	20.00	Wages	21,752	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	\$ 43,505		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: 10/1/15 Ending: 9/30/16

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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 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	Town & Country Bank		X	Mortgage - refinanced		7/1/13	\$ 486,000	\$	9/16/16	3.5000	\$ 12,842	1	
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500		11/14/15	3.9500	17	2	
3	Related Parties	X		Interest income						0.2200	(622)	3	
4	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	667,200	667,200	9/16/19	3.6500		4	
5												5	
	Working Capital												
6	Town & Country Bank		X	Working Capital		2/9/10	168,000			4.5000	2,066	6	
7	Town & Country Bank		X	Interest Income							(8)	7	
8	Hickory Point Bank		X	Working Capital		9/16/16	168,000	168,000		3.5000		8	
9	TOTAL Facility Related						\$ 1,511,700	\$ 835,200			\$ 14,295	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)							\$ 1,511,700	\$ 835,200			\$ 14,295	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 2015 report.			\$	10,317	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.)			\$	13,119	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,802	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	10,492	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.			\$	13,294	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	9,504	8	
		2012	10,283	9	
		2013	10,292	10	
		2014	10,500	11	
		2015	10,590	12	
Line 2, R/E taxes paid: Marigold Estates bill \$10,590 + \$2,529 Central Office bill = \$13,119				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
Line 4, R/E tax accrual: 9/12 Marigold Estates bill \$7,942 + Central Office bill \$2,550 = \$10,492				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 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 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. 11-11-07-107-009	Sec 7 T24N R4W PT E 1/2 NW	\$ 10,589.96	\$ 10,589.96
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 10,589.96	\$ 10,589.96

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:

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

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	\$	39	\$ 6,866	\$ 6,866	\$ 156,833
5										
6										
7										
8	Central Office		2005		79,729		39	2,193	2,193	18,918
	Improvement Type**									
9	Bathroom/kitchen lumber, hardware & flooring			1996	10,099	463	20	463		10,099
10	Carpet, tile, flooring			1996	6,070	156	39	156		3,126
11	Bathroom remodeling			1998	2,940	147	20	147		2,646
12	Painting and wallpaper			2002	5,534		7			5,534
13	Carpet			2004	3,797		5			3,797
14	Carpet			2005	603		7			603
15	Carpet			2005	3,445		7			3,445
16	Kitchen/bathroom lumber, drywall & flooring			2005	4,248	109	39	109		1,253
17	Carpet			2005	2,110		7			2,110
18	New driveway			2005	23,276	1,552	15	1,552		17,586
19	Bathroom remodeling - new plumbing, walls & floor			2007	16,852	432	39	432		4,175
20	New roof			2009	12,000	308	39	308		2,231
21	Carpet - Entire facility			2012	8,188	1,169	7	1,169		5,264
22	New plank floor			2014	665	95	7	95		230
23	New shower stall			2015	5,196	133	39	133		133
24										
25										
26										
27										
28										
29										
30										
31	Central office - track lights & receptacles			2009	216	16	20	16		115
32	New roof			2012	3,133	116	39	116		443
33	Permanent landscaping			2015	1,204	173	10	173		188
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 Marigold Estates

0039370

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)		\$ 462,568	\$ 4,869		\$ 13,928	\$ 9,059	\$ 238,729	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	\$105,886	\$2,121	\$2,121	\$	Varies	\$99,968	71
72	Current Year Purchases	2,030	182	182		7	182	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$107,916	\$2,303	\$2,303	\$		\$100,150	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	\$6,832	\$6,832	\$	5	\$33,594	76
77										77
78										78
79										79
80	TOTALS			\$34,164	\$6,832	\$6,832	\$		\$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)	\$623,270	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$14,004	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$23,063	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,059	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$372,473	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

* 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.

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 99,062	\$ 412,367	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	52,524	341,869	3
4	Supply Inventory (priced at cost)	1,381	6,690	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,393	22,469	7
8	Accounts Receivable (owners or related parties)	666,469	2,776,956	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 824,829	\$ 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	109,576	276,938	15
16	Equipment, at Historical Cost	142,080	615,094	16
17	Accumulated Depreciation (book methods)	(196,722)	(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)	\$ 54,934	\$ 358,091	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 879,763	\$ 3,918,441	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,164	\$ 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	11,221	53,250	30
31	Accrued Taxes Payable (excluding real estate taxes)	604	2,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,492	38,147	32
33	Accrued Interest Payable	947	3,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(225,217)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (191,789)	\$ 226,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,586	39
40	Mortgage Payable	835,200	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)	\$ 835,200	\$ 3,491,586	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 643,411	\$ 3,718,134	46
47	TOTAL EQUITY(page 18, line 24)	\$ 236,352	\$ 200,307	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 879,763	\$ 3,918,441	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 264,147	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 264,147	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	56,107	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)	\$ (27,795)	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)	\$ 236,352	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marigold Estates

0039370

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	\$ 659,958	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 659,958	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	22,359	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,359	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	193,772	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 193,772	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 876,089	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	147,833	31
32	Health Care	387,023	32
33	General Administration	171,664	33
	B. Capital Expense		
34	Ownership	73,480	34
	C. Ancillary Expense		
35	Special Cost Centers	469	35
36	Provider Participation Fee	39,513	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 819,982	40
41	Income before Income Taxes (line 30 minus line 40)**	56,107	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 56,107	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 659,958	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)	\$ 659,958	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					9
10	Activity Assistants	2,644	2,727	24,742	9.07	10
11	Social Service Workers	2,539	2,547	40,197	15.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,590	1,741	20,250	11.63	14
15	Cook Helpers/Assistants	1,049	1,049	9,934	9.47	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,999	4,138	41,840	10.11	18
19	Laundry					19
20	Administrator	407	499	15,446	30.95	20
21	Assistant Administrator					21
22	Other Administrative	922	998	43,505	43.59	22
23	Office Manager					23
24	Clerical	457	499	8,374	16.78	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)	10,607	10,773	109,329	10.15	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,214	24,971	\$ 313,617 *	\$ 12.56	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	28	\$ 1,393	1,3	35
36	Medical Director	\$100/mo	1,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	239	9,578	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	86	10a,3	40
41	Occupational Therapy Consultant	1	107	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	85	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	11	915	12	45
46	Other(specify)				46
47	Psychologist Consultant	15	1,172	10a,3	47
48	Psychiatrist Consultant	2	147	10a,3	48
49	TOTAL (lines 35 - 48)	298	\$ 14,683		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Richard L. Grader	Administrative	100	\$ 21,753
Daniel P. Caulkins	Administrative		21,752
Lora A. Dillman	Administrative		15,446
Jennifer Haseley	Office Assistant		8,374
	Administrative		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,325
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		\$ 3,948
Sikich	CPA		11,390
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,338
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 5,075
Unemployment Compensation Insurance			2,764
FICA Taxes			23,060
Employee Health Insurance			13,041
Employee Meals			109
Illinois Municipal Retirement Fund (IMRF)*			
Long Term Care Insurance			1,635
Employee Medical Expenses			564
Other Employee Expenses			5,889
TOTAL (agree to Schedule V, line 22, col.8)			\$ 52,137
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			1,306
Health Care Worker Background Check (Indicate # of checks performed)	3		
Patient Background Checks	2		
Dues and subscriptions			389
Fees and licenses			121
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 1,816
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			247
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 247

*** Attach copy of IMRF notifications**

****See instructions.**

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? 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. \$ 39,026
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. \$ 469
- 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

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

(#0039370)

10/1/15 - 9/30/16

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

(#0039370)

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
Marigold Estates (#0039370)
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

(#0039370)

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:

- 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, 2016
The group consists of four DD homes (16 beds each) and two CILA homes (10 beds)
All 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

(#0039370)

10/1/15 - 9/30/16

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

Marigold Estates, #0039370

10/1/15 - 9/31/16

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>22,359</u>
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Line 28, Other Revenue

Earning Credits	3,256
Residents' travel reimbursement	469
Gain on asset disposal	309
Miscellaneous income	25
Workshop	<u>189,713</u>
	193,772

**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.