

		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>0037341</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Patterson House</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>307 East Jefferson</u> <u>Sullivan</u> <u>61951</u>			
Number City Zip Code			
County: <u>Moultrie</u>			
Telephone Number: <u>(217) 728-4357</u> Fax # <u>(217) 782-2017</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>	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(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	

#	0037341	Report Period Beginning:	10/1/15	Ending:	9/30/16
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D. How many bed-hold days during this year were paid by the Department?

189 (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?

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

I. On what date did you start providing long term care at this location?

Date started 11/15/1991

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

YES ☐ Date _____ NO ☒

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

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED CASH*	☐	CASH*	☐
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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.**

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.19%

Facility Name & ID Number Patterson House # 0037341 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	29,913	2,468	1,488	33,869		33,869		33,869			1
2	Food Purchase		35,858		35,858		35,858		35,858			2
3	Housekeeping	37,460	2,972		40,432		40,432		40,432			3
4	Laundry		813		813		813		813			4
5	Heat and Other Utilities			24,456	24,456		24,456		24,456			5
6	Maintenance		2,284	27,794	30,078		30,078		30,078			6
7	Other (specify):*											7
8	TOTAL General Services	67,373	44,395	53,738	165,506		165,506		165,506			8
	B. Health Care and Programs											
9	Medical Director			3,850	3,850		3,850		3,850			9
10	Nursing and Medical Records	117,288	5,692	8,562	131,542		131,542		131,542			10
10a	Therapy			2,353	2,353		2,353		2,353			10a
11	Activities	32,153	1,739		33,892		33,892		33,892			11
12	Social Services	35,713		690	36,403		36,403		36,403			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			178,590	178,590		178,590	(178,590)				15
16	TOTAL Health Care and Programs	185,154	7,431	194,045	386,630		386,630	(178,590)	208,040			16
	C. General Administration											
17	Administrative	72,933			72,933		72,933		72,933			17
18	Directors Fees											18
19	Professional Services			16,526	16,526		16,526	(5,330)	11,196			19
20	Dues, Fees, Subscriptions & Promotions			1,329	1,329		1,329	(227)	1,102			20
21	Clerical & General Office Expenses		5,814	9,292	15,106		15,106		15,106			21
22	Employee Benefits & Payroll Taxes			57,085	57,085		57,085	(134)	56,951			22
23	Inservice Training & Education			756	756		756		756			23
24	Travel and Seminar			36	36		36		36			24
25	Other Admin. Staff Transportation			10,712	10,712	(966)	9,746		9,746			25
26	Insurance-Prop.Liab.Malpractice			6,884	6,884		6,884		6,884			26
27	Other (specify):*											27
28	TOTAL General Administration	72,933	5,814	102,620	181,367	(966)	180,401	(5,691)	174,710			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	325,460	57,640	350,403	733,503	(966)	732,537	(184,281)	548,256			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			10,143	10,143		10,143	2,193	12,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,256	9,256		9,256	6,231	15,487			32
33	Real Estate Taxes			9,683	9,683		9,683		9,683			33
34	Rent-Facility & Grounds			7,800	7,800		7,800	(7,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,020	1,020		1,020	(1,020)				36
37	TOTAL Ownership			37,902	37,902		37,902	(396)	37,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					966	966		966			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,649	39,649		39,649	(494)	39,155			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			39,649	39,649	966	40,615	(494)	40,121			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	325,460	57,640	427,954	811,054		811,054	(185,171)	625,883			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	(178,590)	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	(173)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(494)	42		18
19	Entertainment	(134)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,330)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(54)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,020)	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)	\$ (185,795)		\$	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)	624	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 624		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (185,171)		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		\$ 966	25	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 966		47

Patterson House	
ID#	0037341
Report Period Beginning:	10/1/15
Ending:	9/30/16

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 Patterson House # 0037341 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):*	(178,590)	0	0	0	0	0	0	0	0	0	0	(178,590)	15
16	TOTAL Health Care and Programs	(178,590)	0	0	0	0	0	0	0	0	0	0	(178,590)	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	(5,330)	0	0	0	0	0	0	0	0	0	0	(5,330)	19
20	Fees, Subscriptions & Promotions	(227)	0	0	0	0	0	0	0	0	0	0	(227)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(134)	0	0	0	0	0	0	0	0	0	0	(134)	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	(5,691)	0	0	0	0	0	0	0	0	0	0	(5,691)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(184,281)	0	0	0	0	0	0	0	0	0	0	(184,281)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House # 0037341 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	2,193	0	0	0	0	0	0	0	0	0	2,193	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,231	0	0	0	0	0	0	0	0	0	6,231	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(7,800)	0	0	0	0	0	0	0	0	0	(7,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,020)	0	0	0	0	0	0	0	0	0	0	(1,020)	36
37	TOTAL Ownership	(1,020)	624	0	0	0	0	0	0	0	0	0	(396)	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	(494)	0	0	0	0	0	0	0	0	0	0	(494)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(494)	0	0	0	0	0	0	0	0	0	0	(494)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(185,795)	624	0	0	0	0	0	0	0	0	0	(185,171)	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	32	Interest	\$	Two-Can, Inc	100.00%	\$ 1,728	\$ 1,728	1
2	V	30	Depreciation		R&D LLP	100.00%	2,193	2,193	2
3	V	32	Interest		R&D LLP	100.00%	4,503	4,503	3
4	V	34	Rent	7,800	R&D LLP	100.00%		(7,800)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 7,800			\$ 8,424	\$ * 624	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 Patterson House # 0037341 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	\$ 23,565	17,1	1
2	Daniel P. Caulkins	Vice President	Administration		See attached	10	20.00	Wages	23,565	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	\$ 47,130		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 Patterson House

0037341

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See attached schedule				\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Town & Country Bank		X	Mortgage - refinanced		7/1/13	\$ 486,000	\$	9/16/16	3.5000	\$ 14,272	1		
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500		11/14/15	3.9500	19	2		
3	Related Parties	X		Interest income						0.2200	(673)	3		
4	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	722,800	722,800	9/16/19	3.6500		4		
5												5		
	Working Capital													
6	Town & Country Bank		X	Working Capital		2/9/10	182,000			4.5000	2,238	6		
7	Town & Country Bank		X	Interest Income							(9)	7		
8	Hickory Point Bank		X	Working Capital		9/16/16	182,000	182,000		3.5000		8		
9	TOTAL Facility Related						\$ 1,595,300	\$ 904,800				\$ 15,847	9	
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$				\$	14	
15	TOTALS (line 9+line14)						\$ 1,595,300	\$ 904,800				\$ 15,847	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.			\$	5,947	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.)			\$	9,415	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3,468	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	6,215	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.			\$	9,683	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	6,066	8	
		2012	6,203	9	
		2013	6,445	10	
		2014	6,475	11	
		2015	6,675	12	
Line 2, R/E taxes paid: Patterson House bill \$6,675 + \$2,740 Central Office bill = \$9,415		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
Line 4, R/E tax accrual: 9/12 Patterson House bill \$5,007 + Central Office bill \$1,208 = \$6,215		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.

FACILITY NAME Patterson House COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0037341

CONTACT PERSON REGARDING THIS REPORT David W. White C.P.A.

TELEPHONE (217) 423-6000 FAX #: (217) 423-6100

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.

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.)

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 provide copies of their original **second installment** tax bill.**

A. Square Feet: 4,900

B. General Construction Type: Exterior Brick-Metal 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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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	15,000	1991	\$ 20,550	1
	2				2
	3 TOTALS	15,000		\$ 20,550	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	\$ 230,924	\$ 5,773	39	\$ 5,773	\$	\$ 145,332	4
5											5
6											6
7											7
8	Central Office		2005		79,729		39	2,193	2,193	18,918	8
	Improvement Type**										
9	Driveways		1991		16,799		40			16,799	9
10	Landscaping		1991		4,593		10			4,593	10
11	New floor/tile		1998		2,759		10			2,759	11
12	New carpet		2000		2,810		10			2,810	12
13	New roof		2007		11,410	571	20	571		5,230	13
14	Bathroom/kitchen remodeling		2007		3,223	215	15	215		1,880	14
15	(2) exit doors		2008		3,866	257	15	257		2,019	15
16	(3) outswing entry doors		2009		3,025	202	15	202		1,395	16
17	(2) Furnaces		2013		7,991	205	39	205		683	17
18	Bathroom remodel - tub/shower surround, faucet, 2 assist bars		2016		6,598		39				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	Central office - track lights & receptacles		2009		216	17	20	17		125	31
32	New roof		2012		3,133	125	39	125		480	32
33	Permanent landscaping		2015		1,204	188	10	188		203	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Patterson House

0037341

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)		\$ 378,280	\$ 7,553		\$ 9,746	\$ 2,193	\$ 203,226	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	\$124,242	\$2,208	\$2,208	\$	Varies	\$120,080	71
72	Current Year Purchases	15,176	382	382		7	382	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$139,418	\$2,590	\$2,590	\$		\$120,462	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$538,248	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$10,143	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$12,336	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,193	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$323,688	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.

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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 107,146	\$ 412,367	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,178	341,869	3
4	Supply Inventory (priced at cost)	1,829	6,690	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,842	22,469	7
8	Accounts Receivable (owners or related parties)	722,008	2,776,956	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 933,003	\$ 3,560,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,550	20,550	13
14	Buildings, at Historical Cost	291,187	291,187	14
15	Leasehold Improvements, at Historical Cost	7,363	276,938	15
16	Equipment, at Historical Cost	141,819	615,094	16
17	Accumulated Depreciation (book methods)	(307,171)	(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)	\$ 153,748	\$ 358,091	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,086,751	\$ 3,918,441	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,874	\$ 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	11,328	53,250	30
31	Accrued Taxes Payable (excluding real estate taxes)	654	2,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,215	38,147	32
33	Accrued Interest Payable	1,025	3,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(835,369)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (796,273)	\$ 226,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,586	39
40	Mortgage Payable	904,800	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)	\$ 904,800	\$ 3,491,586	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 108,527	\$ 3,718,134	46
47	TOTAL EQUITY(page 18, line 24)	\$ 978,224	\$ 200,307	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,086,751	\$ 3,918,441	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,004,844	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,004,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,282	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)	\$ (26,620)	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)	\$ 978,224	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Patterson House

0037341

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	\$ 665,374	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 665,374	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	23,380	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,380	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	179,582	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 179,582	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 868,336	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	165,506	31
32	Health Care	386,630	32
33	General Administration	180,401	33
	B. Capital Expense		
34	Ownership	37,902	34
	C. Ancillary Expense		
35	Special Cost Centers	966	35
36	Provider Participation Fee	39,649	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 811,054	40
41	Income before Income Taxes (line 30 minus line 40)**	57,282	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,282	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 665,374	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)	\$ 665,374	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,602	1,664	18,925	11.37	9
10	Activity Assistants	1,322	1,322	13,228	10.01	10
11	Social Service Workers	2,488	2,640	35,713	13.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,970	2,103	25,010	11.89	14
15	Cook Helpers/Assistants	493	493	4,903	9.95	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,787	3,986	37,460	9.40	18
19	Laundry					19
20	Administrator	440	541	16,731	30.93	20
21	Assistant Administrator					21
22	Other Administrative	998	1,082	47,130	43.56	22
23	Office Manager					23
24	Clerical	495	541	9,072	16.77	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)	10,554	11,019	117,288	10.64	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,149	25,391	\$ 325,460 *	\$ 12.82	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	30	\$ 1,488	1,3	35
36	Medical Director	monthly fee	3,850	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	182	7,288	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	12	562	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	9	690	12	45
46	Other(specify)				46
47	Psychologist Consultant	15	1,209	10a,3	47
48	Psychiatrist Consultant	7	582	10a,3	48
49	TOTAL (lines 35 - 48)	255	\$ 15,669		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
Richard L. Grader	Administrative	100	\$ 23,565	Workers' Compensation Insurance		\$ 5,498	IDPH License Fee	\$
Daniel P. Caulkins	Administrative		23,565	Unemployment Compensation Insurance		2,552	Advertising: Employee Recruitment	106
Lora A. Dillman	Administrative		16,731	FICA Taxes		23,198	Health Care Worker Background Check	
Jennifer Haseley	Office Assistant		9,072	Employee Health Insurance		14,127	(Indicate # of checks performed 3)	
	Administrative			Employee Meals		163	Patient Background Checks	2
				Illinois Municipal Retirement Fund (IMRF)*			Dues and subscriptions	744
				Long Term Care Insurance		1,771	Fees and licenses	252
				Employee Medical Expenses		5,256		
				Other Employee Expenses		4,386		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								

*** 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. \$ 39,649
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 benefit 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. \$ 966
- 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, (#0037341)

10/1/15 - 9/31/16

Page 4, Part V

Line 36, Other

IL replacement tax

1,020

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

(#0037341)

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

(#0037341)

10/1/15 - 9/30/16

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>
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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
Patterson House (#0037341)

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

(#0037341)

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
Marigold Estates
Patterson House
(#0037341)

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

(#0037341)

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

Patterson House, (#0037341) 10/1/15 - 9/31/16

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>23,380</u>
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Line 28, Other Revenue

Social security reimbursement	(1,406)
Earning Credits	1,070
Residents' travel reimbursement	966
Gain on asset disposal	335
Miscellaneous income	27
Workshop	<u>178,590</u>
	179,582

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

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.