

		FOR BHF USE					

LL1

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2020)

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:

0039370

Facility Name:

Marigold Estates

Address:

3240 Barney Avenue

Pekin

61554

Number

City

Zip Code

County:

Tazewell

Telephone Number:

309-347-6514

Fax #

309-347-6146

HFS ID Number:

Date of Initial License for Current Owners:

10/26/94

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

X

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name:

Stephanie A. Price

Telephone Number:

217-423-6000

Email Address:

II.

CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from

10/1/19

to

9/30/20

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.

Officer or Administrator of Provider

(Signed)

(Date)

(Type or Print Name)

Richard L. Grader

(Title)

President

Paid Preparer

(Signed)

(Date)

1/26/2021

(Print Name and Title)

Stephanie A. Price, CPA

Senior Manager

(Firm Name & Address)

Sikich LLP

132 S. Water St., Ste 300, Decatur IL, 62523

(Telephone)

217-423-6000

Fax #

217-423-6100

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

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Marigold Estates

0039370 Report Period Beginning: 10/1/19 Ending: 9/30/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,841</u>	6
7	16	TOTALS	16	5,841	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	<u>5,689</u>			<u>5,689</u>	13
14	TOTALS	5,689			5,689	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.40%

D. How many bed reserve days during this year were paid by the Department? 17 (Do not include bed reserve 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 12/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/1993 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 9/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/1/19 Ending: 9/30/20
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	14,239	1,005	1,437	16,681		16,681		16,681			1
2	Food Purchase		39,794		39,794		39,794		39,794			2
3	Housekeeping	43,349	6,702		50,051		50,051		50,051			3
4	Laundry		418		418		418		418			4
5	Heat and Other Utilities			25,981	25,981		25,981		25,981			5
6	Maintenance		3,573	18,228	21,801		21,801		21,801			6
7	Other (specify):* Disposal/garbage			1,493	1,493		1,493		1,493			7
8	TOTAL General Services	57,588	51,492	47,139	156,219		156,219		156,219			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	159,144	7,858	12,129	179,131		179,131		179,131			10
10a	Therapy			370	370		370		370			10a
11	Activities	15,749	2,058		17,807		17,807		17,807			11
12	Social Services	51,753		138	51,891		51,891		51,891			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			228,835	228,835		228,835	(228,835)				15
16	TOTAL Health Care and Programs	226,646	9,916	242,672	479,234		479,234	(228,835)	250,399			16
	C. General Administration											
17	Administrative	52,310		7	52,317		52,317	(7)	52,310			17
18	Directors Fees											18
19	Professional Services			13,036	13,036		13,036		13,036			19
20	Dues, Fees, Subscriptions & Promotions			1,892	1,892		1,892	(849)	1,043			20
21	Clerical & General Office Expenses		5,507	5,948	11,455		11,455		11,455			21
22	Employee Benefits & Payroll Taxes			50,010	50,010		50,010	(10)	50,000			22
23	Inservice Training & Education			452	452		452		452			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,684	10,684	(5,839)	4,845		4,845			25
26	Insurance-Prop.Liab.Malpractice			9,913	9,913		9,913		9,913			26
27	Other (specify):* Contributions			40	40		40	(40)				27
28	TOTAL General Administration	52,310	5,507	91,982	149,799	(5,839)	143,960	(906)	143,054			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	336,544	66,915	381,793	785,252	(5,839)	779,413	(229,741)	549,672			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			5,256	5,256		5,256	10,425	15,681			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,738	6,738		6,738	4,212	10,950			32
33	Real Estate Taxes			11,887	11,887		11,887		11,887			33
34	Rent-Facility & Grounds			36,696	36,696		36,696	(36,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State repl tax			1,480	1,480		1,480	(1,480)				36
37	TOTAL Ownership			62,057	62,057		62,057	(23,539)	38,518			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					5,839	5,839		5,839			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,096	44,096		44,096		44,096			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			44,096	44,096	5,839	49,935		49,935			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	336,544	66,915	487,946	891,405		891,405	(253,280)	638,125			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	(228,835)	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	(780)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7)	17		18
19	Entertainment	(10)	22		19
20	Contributions	(40)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(69)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,480)	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)	\$ (231,221)		\$	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)	(22,059)	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,059)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (253,280)		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		\$ 5,839	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)			\$ 5,839		47

Marigold Estates

ID# 0039370

Report Period Beginning: 10/1/19

Ending: 9/30/20

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: 10/1/19 Ending: 9/30/20

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):*	(228,835)	0	0	0	0	0	0	0	0	0	0	(228,835)	15
16	TOTAL Health Care and Programs	(228,835)	0	0	0	0	0	0	0	0	0	0	(228,835)	16
	C. General Administration													
17	Administrative	(7)	0	0	0	0	0	0	0	0	0	0	(7)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(849)	0	0	0	0	0	0	0	0	0	0	(849)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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):*	(40)	0	0	0	0	0	0	0	0	0	0	(40)	27
28	TOTAL General Administration	(906)	0	0	0	0	0	0	0	0	0	0	(906)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(229,741)	0	0	0	0	0	0	0	0	0	0	(229,741)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marigold Estates # 0039370 Report Period Beginning: 10/1/19 Ending: 9/30/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	10,425	0	0	0	0	0	0	0	0	0	10,425	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	4,212	0	0	0	0	0	0	0	0	0	4,212	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):*	(1,480)	0	0	0	0	0	0	0	0	0	0	(1,480)	36
37	TOTAL Ownership	(1,480)	(22,059)	0	0	0	0	0	0	0	0	0	(23,539)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(231,221)	(22,059)	0	0	0	0	0	0	0	0	0	(253,280)	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	TwoCan, Inc	Decatur	Landlord
		Emerald Estates	Canton	RLG Real Estate, LLC	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	\$	TwoCan, Inc	100.00%	\$ 6,866	\$ 6,866	1
2	V	32	Interest		TwoCan, Inc	100.00%	1,073	1,073	2
3	V	34	Rent	29,496	TwoCan, Inc	100.00%		(29,496)	3
4	V	30	Depreciation		RLG Real Estate, LLC	100.00%	3,559	3,559	4
5	V	32	Interest		RLG Real Estate, LLC	100.00%	3,139	3,139	5
6	V	34	Rent	7,200	RLG Real Estate, LLC	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			\$ 14,637	\$ * (22,059)	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: 10/1/19 Ending: 9/30/20

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	\$ 19,545	17,1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,545		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: 10/1/19 Ending: 9/30/20

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
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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		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	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	\$ 667,200	\$ 435,083		3.7500	\$ 8,933	1	
2	Related Parties	X		Interest Income							(858)	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Hickory Point Bank		X	Working Capital		9/16/16	168,000			3.2500	3,043	6	
7	Hickory Point Bank		X	Interest Income							(168)	7	
8												8	
9	TOTAL Facility Related						\$ 835,200	\$ 435,083			\$ 10,950	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 835,200	\$ 435,083			\$ 10,950	15	

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

* 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 2019 report.			\$	10,119	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	12,920	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,801	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	9,086	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.			\$	11,887	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	10,590	8	
		2016	10,808	9	
		2017	11,027	10	
		2018	10,131	11	
		2019	10,412	12	
Line 2, R/E taxes paid: Marigold Estates \$10,131 bill + \$2,507 Central Office bill = \$12,920		13	FROM R. E. TAX STATEMENT FOR 2019 \$		13
Line 4, R/E tax accrual: 9/12 Marigold Estates bill \$7,809 + Central Office bill \$1,277 = \$9,086		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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Estates COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0039370

CONTACT PERSON REGARDING THIS REPORT Stephanie A. Price, CPA

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 2019 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 2019.

(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(225x225)	\$ 10,412.30	\$ 10,412.30
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 10,412.30	\$ 10,412.30

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

4,356

B. General Construction Type:

Exterior

Brick-Vinyl

Frame

Wood

Number of Stories

one

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	\$ 191,164
5										
6										
7										
8	Central Office		2005		132,849		39	3,559	3,559	24,226
	Improvement Type**									
9	Bathroom/kitchen lumber, hardware & flooring			1996	10,099		20			10,099
10	Carpet, tile, flooring			1996	6,070	156	39	156		3,748
11	Bathroom remodeling			1998	2,940		20			2,940
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	108	39	108		1,688
17	Carpet			2005	2,110		7			2,110
18	New driveway			2005	23,276	1,035	15	1,035		23,276
19	Bathroom remodeling - new plumbing, walls & floor			2007	16,852	432	39	432		5,903
20	New roof			2009	12,000	308	39	308		3,461
21	Carpet - Entire facility			2012	8,188		7			8,188
22	New plank floor			2014	665	95	7	95		609
23	New shower stall			2015	5,196	133	39	133		666
24	Remodel, 2 mens' bathrooms: Tile, shower stalls, flooring, sinks, toilets, and lighting			2016	5,352	137	39	137		537
25										
26										
27										
28										
29										
30										
31	Central Office - tracklights & receptacles			2009	216	16	20	16		177
32	New roof			2012	3,133	116	39	116		906
33	Permanent landscaping			2015	1,203	173	10	173		881
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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)		\$ 521,039	\$ 2,709		\$ 13,134	\$ 10,425	\$ 293,958	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	\$119,041	\$2,547	\$2,547	\$		\$108,120	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$119,041	\$2,547	\$2,547	\$		\$108,120	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	\$	\$	\$	5	\$34,164
77									
78									
79									
80	TOTALS			\$34,164	\$	\$	\$		\$34,164

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)			\$	692,866
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	5,256
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	15,681
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	10,425
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	436,242

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	Vehicle - Range Rover	\$10,892	\$	\$
87				
88				
89				
90				
91	TOTALS	\$10,892	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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	\$ 20,193	\$ 83,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	129,873	541,968	3
4	Supply Inventory (priced at cost)	1,460	7,192	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,562	85,674	7
8	Accounts Receivable (owners or related parties)	490,604	2,044,183	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 662,692	\$ 2,762,831	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		311,689	14
15	Leasehold Improvements, at Historical Cost	114,928	313,803	15
16	Equipment, at Historical Cost	164,096	740,456	16
17	Accumulated Depreciation (book methods)	(220,856)	(997,791)	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)	\$ 58,168	\$ 388,707	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 720,860	\$ 3,151,538	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,717	\$ 19,656	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,979	91,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	233	972	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,086	39,436	32
33	Accrued Interest Payable	726	3,025	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(263,671)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (229,930)	\$ 154,447	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	99,108	445,893	39
40	Mortgage Payable	435,083	1,812,846	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)	\$ 534,191	\$ 2,258,739	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 304,261	\$ 2,413,186	46
47	TOTAL EQUITY(page 18, line 24)	\$ 416,599	\$ 738,352	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 720,860	\$ 3,151,538	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 255,488	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 255,488	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	219,401	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	(58,290)	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)	\$ 161,111	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)	\$ 416,599	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marigold Estates

0039370

Report Period Beginning: 10/1/19

Ending:

9/30/20

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	\$ 853,796	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 853,796	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	20,055	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	1,847	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 21,902	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, PG 29	235,108	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 235,108	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,110,806	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	156,219	31
32	Health Care	479,234	32
33	General Administration	143,960	33
	B. Capital Expense		
34	Ownership	62,057	34
	C. Ancillary Expense		
35	Special Cost Centers	5,839	35
36	Provider Participation Fee	44,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 891,405	40
41	Income before Income Taxes (line 30 minus line 40)**	219,401	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 219,401	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	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)	\$	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	861	861	10,398	12.08	9
10	Activity Assistants	646	646	5,351	8.28	10
11	Social Service Workers	2,080	2,080	51,753	24.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,052	1,157	14,239	12.31	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,676	3,736	43,349	11.60	18
19	Laundry					19
20	Administrator	482	499	14,329	28.72	20
21	Assistant Administrator					21
22	Other Administrative	461	499	19,545	39.17	22
23	Office Manager					23
24	Clerical	897	946	18,436	19.49	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)	13,243	13,324	159,144	11.94	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,398	23,748	\$ 336,544 *	\$ 14.17	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	29	\$ 1,437	1,3	35
36	Medical Director	100/month	1,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	323	11,319	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1	101	10a,3	40
41	Occupational Therapy Consultant	1	101	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	128	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	2	138	12,3	45
46	Other(specify)				46
47	Psychologist Consultant	1	40	10a,3	47
48	Psychiatrist Consultant				48
49	TOTAL (lines 35 - 48)	359	\$ 14,464		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			
Name	Function	%	Amount
Richard Grader	Administrative	100	\$ 19,545
Jennifer Haseley	Office Assistant		13,167
Chelsea Hauschildt	Office Assistant		5,269
Nicki Palmer	Administrative		14,329
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,310
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
Eck, Schafer & Punke	CPA	\$	2,400
Sikich	CPA		10,417
Summit Tax & Acctg.	CPA		212
Shield Screening LLC	Security		7
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 13,036
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	8,112
Unemployment Compensation Insurance			1,439
FICA Taxes			25,746
Employee Health Insurance			10,712
Employee Meals			2,156
Illinois Municipal Retirement Fund (IMRF)*			
Employee Medical Expense			109
Other Employee Expense			1,726
TOTAL (agree to Schedule V, line 22, col.8)			\$ 50,000
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			
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Fees and Licenses			485
Dues and Subscriptions			558
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 1,043
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	

*** 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 years
- (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. \$ 44,096
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. \$ 5,839
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

10/1/19 - 9/30/20

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 TwoCan, Inc. on its mortgage was:

Hickory Point Bank:

The interest is allocated as follows:

Carlinville Estates	1,073
Emerald Estates	626
Marigold Estates	1,072
Patterson House	<u>1,162</u>
	<u><u>3,933</u></u>

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

10/1/19 - 9/30/20

#0039370

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability corporation, Richard Grader Real Estate LLC, which has the same shareholders as Patterson House, Inc.

Richard Grader Real Estate, LLC has the following basis in the building:

Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House

Interest accrued by Richard Grader Real Estate, LLC on its mortgage was as follows:

Hickory Point Bank

11,512

The interest is allocated as follows:

Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House

3,140
1,831
3,140
3,401

11,512

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

#0039370

10/1/19 - 9/30/20

Page 7, Part VII, C

Owners' Compensation
10/1/19 - 9/30/20

	<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	81,439	19,545	11,401	19,545	21,174	4,072	5,702

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

10/1/19 - 9/30/20

#0039370

Owners' Compensation
10/1/19 - 9/30/20

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

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

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.

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2020
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.

	<u>Total Expense</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>	<u>CILA Homes</u>	<u>Line Ref</u>
Food Costs	1,136	454	264	454	491	227	1
Housekeeping Supplies	597	102	60	102	110	51	3
Utilities	13,911	3,269	1,907	3,269	3,541	1,634	5
Maintenance	6,335	1,648	961	1,648	1,786	824	6
Nondepreciable equipment (consumable items)	669	140	99	157	169	17	7
Nursing Consultant fees	240	362	211	362	392	182	10
Administrative Salaries	197,394	46,803	27,301	46,802	50,703	23,401	17
Penalties	-						17
Professional Services	58,924	13,464	7,854	13,464	14,587	6,733	19
Dues, Fees and Subscriptions	5,329	1,895	1,106	1,895	2,053	948	20
Contributions	165	438	255	438	474	219	20
Advertising	-						20
Office Supplies	5,249	1,437	838	1,437	1,556	718	21
Other Office Expense	3,678	339	198	339	367	170	21
Postage	2,683	354	206	354	383	177	21
Telephone	10,356	2,663	1,553	2,663	2,885	1,331	21
Payroll Taxes	13,658	3,309	1,931	3,309	3,585	1,655	22
Group Health Insurance	67,522	14,747	8,603	14,747	15,976	7,374	22
Workers Comp Insurance	33,799	8,409	4,905	8,409	9,110	4,205	22
Business Meals	8,010	2,428	1,417	2,428	2,631	1,214	22
Entertainment	40	656	382	656	710	328	22
Other Employee Benefits	4,105	2,715	1,584	2,715	2,941	1,358	22
Inservice Training & Education	384	639	373	639	693	320	23
Other Admin/Staff Transportation	25,681	9,312	5,432	9,312	10,087	4,655	25
Insurance	43,389	7,594	4,430	7,594	8,227	3,796	26
Depreciation	3,326	809	472	809	877	405	30
Interest Expense	35,503	11,503	6,710	11,503	12,462	5,752	32
Real Estate Taxes	12,400	2,445	1,427	2,445	2,649	1,223	33
Lease - Central Office	30,000	7,200	4,200	7,200	7,800	3,600	34
IL replacement tax	6,166	480	280	480	520	240	36
	590,650	145,614	84,959	145,630	157,765	72,757	

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

#0039370

10/1/19 - 9/30/20

Page 9, Part IX

Mortgage

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

Balance @ 9/30/20

1,812,846

Carlinville Estates	435,083
Emerald Estates	253,798
Marigold Estates	435,083
Patterson House	471,340

Patterson House, Inc.
Marigold Estates

#0039370

10/1/19 - 9/30/20

Line 21, Other Medical Services

HAB Aid training reimbursement

-

Line 28, Other Revenue

Social Security

-

Earning Credits

414

Residents' travel reimbursement

5,839

Miscellaneous income

20

Workshop

228,835

235,108

**Facility fiscal year end is 9/30/20, tax year end is 12/31/20.
Taxable income will not agree.

Patterson House, Inc.
Marigold Estates

#0039370

10/1/19 - 9/30/20

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.

Marigold Estates

#0039370

10/1/19 - 9/30/20

Page 3, Part V

Line 25, Other Admin Staff Transportation

Vehicle expense	601
Vehicle fuel	2,288
Vehicle lease	3,323
Mileage	4,472
Medically necessary transportation	-
	10,684

**Facility fiscal year end is 9/30/20, tax year end is 12/31/20.
Taxable income will not agree.