

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>10/1/24</u> to <u>9/30/25</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>217-728-2017</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>10/26/94</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Richard L. Grader</u> (Title) <u>President</u>																																																	
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.	_____				☐	Limited Liability Co.					☐	Trust					☐	Other _____			Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>William Q. Collins, CPA</u> <u>Senior Manager</u> (Firm Name & Address) <u>Sikich LLC</u> <u>101 S. State St, Ste M220, Decatur, IL 62523</u> (Telephone) <u>217-423-6000</u> Fax # <u>217-423-6100</u>	
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																														
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		☐	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact: Name: <u>William Q. Collins</u> Telephone Number: <u>217-423-600</u> Email Address: _____																																																			
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																																																	

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/24 Ending: 9/30/25

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,686							5,686	13
14	TOTALS	5,686							5,686	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 97.36%

D. How many bed reserve days during this year were paid by the Department? 0 (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? Ues

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 11/15/91

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/15/91 NO ☐

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2024 Fiscal Year: 9/30/2024
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/24 Ending: 9/30/25
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	53,341	2,361	4,650	60,352		60,352		60,352			1
2	Food Purchase		56,326		56,326		56,326		56,326			2
3	Housekeeping	78,048	4,001		82,049		82,049		82,049			3
4	Laundry		1,301		1,301		1,301		1,301			4
5	Heat and Other Utilities			27,625	27,625		27,625		27,625			5
6	Maintenance		4,608	26,106	30,714		30,714		30,714			6
7	Other (specify):* Garbage			5,108	5,108		5,108		5,108			7
8	TOTAL General Services	131,389	68,597	63,489	263,475		263,475		263,475			8
	B. Health Care and Programs											
9	Medical Director			1,625	1,625		1,625		1,625			9
10	Nursing and Medical Records	281,737	4,779	134	286,650		286,650		286,650			10
10a	Therapy			966	966		966		966			10a
11	Activities	63,129	1,432		64,561		64,561		64,561			11
12	Social Services	53,244			53,244		53,244		53,244			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshops			329,485	329,485		329,485	(329,485)				15
16	TOTAL Health Care and Programs	398,110	6,211	332,210	736,531		736,531	(329,485)	407,046			16
	C. General Administration											
17	Administrative	80,173			80,173		80,173		80,173			17
18	Directors Fees											18
19	Professional Services			5,016	5,016		5,016		5,016			19
20	Dues, Fees, Subscriptions & Promotions			940	940		940	(13)	927			20
21	Clerical & General Office Expenses		3,976	7,581	11,557		11,557		11,557			21
22	Employee Benefits & Payroll Taxes			72,941	72,941		72,941		72,941			22
23	Inservice Training & Education			3,058	3,058		3,058		3,058			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			31,604	31,604	(8,873)	22,731		22,731			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):* Contributions			110	110		110	(110)				27
28	TOTAL General Administration	80,173	3,976	121,250	205,399	(8,873)	196,526	(123)	196,403			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	609,672	78,784	516,949	1,205,405	(8,873)	1,196,532	(329,608)	866,924			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			11,850	11,850		11,850	69	11,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(3,005)	(3,005)		(3,005)	(5,891)	(8,896)			32
33	Real Estate Taxes			11,860	11,860		11,860		11,860			33
34	Rent-Facility & Grounds			6,600	6,600		6,600	(6,600)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			27,305	27,305		27,305	(12,422)	14,883			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					8,873	8,873		8,873			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,688	50,688		50,688		50,688			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			50,688	50,688	8,873	59,561		59,561			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	609,672	78,784	594,942	1,283,398		1,283,398	(342,030)	941,368			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	(329,485)	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	(10)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(110)	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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(2,888)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (332,493)	20,30	\$	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	(9,537)		33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (9,537)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (342,030)		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		\$ 8,873	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)			\$ 8,873		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (13)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Depreciation Non-Care Related	(2,875)	30	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	(2,888)		49

Summary A

9/30/25

[illegible]

Summary B

9/30/25

[illegible]

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	32	Interest	\$ 7,827	Twocan, Inc.	100.00%	\$ 565	\$ (7,262)	1
2	V	30	Depreciation		RLG Real Estate, LLC	100.00%	2,944	2,944	2
3	V	32	Interest		RLG Real Estate, LLC	100.00%	1,381	1,381	3
4	V	34	Rent	6,600	RLG Real Estate, LLC	100.00%		(6,600)	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			\$ 14,427			\$ 4,890	\$ * (9,537)	14

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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

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	Administrative	100.00	See attached	10	20.00	Wages	\$ 22,055	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	\$ 22,055		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: 10/1/24 Ending: 9/30/25

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

Ending: 9/30/25

Fax Number

	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						\$	\$		\$	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 - refinance		9/16/16	\$ 667,200	\$ 98,303		6.0000	\$ 4,237	1	
2	Related Parties	X		Interest Income							(15,875)	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Hickory Point Bank		X	Line of Credit				85,451			2,795	6	
7	Related Parties	X		Interest Income							(63)	7	
8												8	
9	TOTAL Facility Related						\$ 667,200	\$ 183,754			\$ (8,906)	9	
	B. Non-Facility Related*												
10	Relanted Parties	X		Vehicle loan		10/1/20	15,684			0.8900	10	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 15,684				\$ 10	14	
15	TOTALS (line 9+line14)						\$ 682,884	\$ 183,754			\$ (8,896)	15	

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	8,237	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.)				\$	11,439	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,202	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	8,658	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.				\$	11,860	7
Assessed Value from Real Estate Tax Bill:	2024	96,448	8			
Real Estate Tax Bill for Calendar Year:	2020	7,098	9			
	2021	7,371	10			
	2022	7,571	11			
	2023	8,354	12			
	2024	8,926	13			
Line 2, R/E taxes paid: Patterson House \$8,926 + Central Office \$2,513 = \$11,439						
Line 4, R/E tax accrual: 9/12 Patterson House \$6,773 + Central Office \$1,885 = \$8,658						

FOR BHF USE ONLY			
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

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 William Q. Collins
TELEPHONE 217-423-6000 FAX #: 217-423-6100

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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: 4,900 B. General Construction Type: Exterior Brick-Metal Frame Wood Number of Stories One

C. Does the Operating Entity? (X) (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? (X) (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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO X 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	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		1991	1991	\$ 230,924	\$ 5,773	39	\$ 5,773		\$ 197,290
5										
6										
7										
8	Central Office		2005		113,871		39	2,944	2,944	35,883
	Improvement Type**									
9	Driveways		1991		16,799		10			16,799
10	Landscaping		1991		4,593		10			4,593
11	New floor/tile		1998		2,759		10			2,759
12	New carpet		2000		2,810		10			2,810
13	New roof		2007		11,410	571	20	571		10,364
14	Bathroom/kitchen remodeling		2007		3,223		15			3,223
15	(2) Exit doors		2008		3,866		15			3,866
16	(3) Outswing Entry Door		2009		3,025	17	15	17		3,025
17	(2) Furnances		2013		7,991	205	39	205		2,527
18	Bathroom remodel - tub/showersurround, faucet, 2 assist bars		2016		6,598	169	39	169		1,523
19	Bathrrom remodel, 2 mens' restrooms, doors, tile, paint, shower stalls, toilet		2017		14,485	371	39	371		3,095
20	Bathroom remodel, 2 mens' restrooms, drywall, grout, backsplash		2017		1,488	38	39	38		318
21	EZ shed		2020		4,529	302	15	302		1,635
22	Bathroom remodel		2024		11,450	286	40	286		406
23	Bathroom remodel. Custom shower, tiled floor, drywall repairs & paint		2024		17,185	394	40	394		394
24										
25										
26										
27										
28										
29										
30										
31	Centrol Office - tracklights & receptacles		2009		285	14	20	14		234
32	New roof		2012		4,136	106	39	106		1,361
33	Premanent landscaping		2015		1,589	146	10	146		1,589
34	Parking lot resurfacing		2022		1,246	83	15	83		249
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$464,262	\$8,475		\$11,419	\$2,944	\$293,943	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	\$ 4,638	\$ 482	\$ 482	\$	5	\$ 4,287	71
72	Current Year Purchases	850	18	18		5	18	72
73	Fully Depreciated Assets	141,692					141,692	73
74								74
75	TOTALS	\$ 147,180	\$ 500	\$ 500	\$		\$ 145,997	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	2017 Chevy Van	2017	\$ 33,561	\$	\$	\$	5	\$ 33,561	76
77										77
78										78
79										79
80	TOTALS			\$ 33,561	\$	\$	\$		\$ 33,561	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 665,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,919	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,944	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 473,501	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	Vehicle - 2020	\$ 14,377	\$ 2,875	\$ 14,377	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,377	\$ 2,875	\$ 14,377	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2026	\$ _____
13.	_____/2027	\$ _____
14.	_____/2028	\$ _____

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

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

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	

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	\$ 7,968	\$ 36,194	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	236,641	1,174,221	3
4	Supply Inventory (priced at Cost)	859	13,591	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,769	21,678	7
8	Accounts Receivable (owners or related parties)	442,910	2,013,226	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 693,147	\$ 3,258,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,550	61,708	13
14	Buildings, at Historical Cost	311,689	422,967	14
15	Leasehold Improvements, at Historical Cost	38,701	498,221	15
16	Equipment, at Historical Cost	195,118	874,273	16
17	Accumulated Depreciation (book methods)	(451,993)	(1,273,344)	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)	\$ 114,065	\$ 583,825	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 807,212	\$ 3,842,735	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 12,261	\$ 55,728	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,100	99,838	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,833	35,605	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,658	67,292	32
33	Accrued Interest Payable	246	1,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Roth Payable	453	2,060	36
37	Intercompany	(1,431,839)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (1,386,288)	\$ 261,640	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	274,617	1,248,261	39
40	Mortgage Payable	98,303	446,833	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)	\$ 372,920	\$ 1,695,094	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,013,368)	\$ 1,956,734	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,820,580	\$ 1,886,001	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 807,212	\$ 3,842,735	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,594,199	1
2	Restatements (describe):		2
3	Income Adjustment	49,675	3
4	Equipment Capitalized	11,450	4
5	Depreciation Adjustment	(119)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,655,205	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	326,000	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	(160,625)	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)	\$ 165,375	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)	\$ 1,820,580	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/1/24

Ending:

9/30/25

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	\$ 1,187,375	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,187,375	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	65,631	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 65,631	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	<u>See attached schedule, Pg 29</u>	362,662	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 362,662	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,615,668	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	263,475	31
32	Health Care	736,531	32
33	General Administration	205,399	33
	B. Capital Expense		
34	Ownership	27,305	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	50,688	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,283,398	40
41	Income before Income Taxes (line 30 minus line 40)**	332,270	41
42	Income Taxes	(6,270)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 326,000	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,035,831.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) <u>Social Security - residents</u>	151,544.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,187,375	56

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	2,040	2,080	67,165	32.29	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	1,059	1,058	20,570	19.44	9
10	Activity Assistants	3,488	3,488	42,559	12.20	10
11	Social Service Workers	2,040	2,080	53,244	25.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	255	255	5,199	20.39	14
15	Cook Helpers/Assistants	2,747	2,747	48,142	17.53	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	6,457	6,457	78,048	12.09	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	448	459	24,829	54.09	21
22	Other Administrative					22
23	Office Manager	448	459	22,055	48.05	23
24	Clerical					24
25	Vocational Instruction	808	808	33,289	41.20	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,369	11,409	214,572	18.81	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,159	31,300	\$ 609,672 *	\$ 19.48	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	36	\$ 4,650	1,3	35
36	Medical Director	125/mo	1,625	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist Consultant	48	966	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	84	\$ 7,241		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Patterson House

0037341Report Period Beginning:10/1/24Ending:9/30/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Richard Grader

Administrative

100

\$ 22,055

Jennifer Haseley

Office Assistant

18,885

Chelsea Hauschildt

Office Assistant

8,185

Nicki Palmer

Administrative

24,829

Tempest Grader

Other Clerical

4,805

Madison Koseter

Other Clerical

1,414

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 80,173

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

Sikich

CPA

\$ 2,372

Eck, Schafer & Punke

CPA

2,618

Summit Tax & Accounting

CPA

26

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 5,016

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 6,287

Unemployment Compensation Insurance

988

FICA Taxes

46,640

Employee Health Insurance

16,278

Employee Meals

430

Illinois Municipal Retirement Fund (IMRF)*

Employee Medical Expense

711

Other Employee Expense

1,607

TOTAL (agree to Schedule V, line 22, col.8)

\$ 72,941

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

Association Dues (total from pg 22, #4)

278

Licenses and Fees

490

Dues and Subscriptions

172

Less: Public Relations Expense

()

PAC and Lobbying payments

(13)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 927

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) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|--|------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>265</u> |
| <u>THE CENTER FOR DEVELOPMENTAL DISABILITIES</u> | |
| | |
| | <u>265</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--|-----------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | |
| <u>THE CENTER FOR DEVELOPMENTAL DISABILITIES</u> | |
| | <u>13</u> |
| | |
| | <u>13</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>265</u> |
| <u>THE CENTER FOR DEVELOPMENTAL DISABILITIES</u> | |
| | <u>13</u> |
| | |
| | <u>278</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ _____ Line _____
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,688
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (12) 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. \$ 8,873
- 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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- 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. \$ _____
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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

#0037341

10/1/24 - 9/30/25

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:

2,056

The interest is allocated as follows:

Carlinville Estates	488
Emerald Estates	463
Marigold Estates	540
Patterson House	<u>565</u>
	<u><u>2,056</u></u>

Patterson House, Inc.10/1/24 - 9/30/25

Carlinville Estates

Emerald Estates

Marigold Estates

Patterson House #0037341

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

5,021

The interest is allocated as follows:

Carlinville Estates1,192

Emerald Estates1,130

Marigold Estates1,318

Patterson House1,381

5,021

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

#0037341

10/1/24 - 9/30/25

Page 7, Part VII, C

Owners' Compensation 10/1/24 - 9/30/25	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	Elin House (CILA)	Greykin House (CILA)	Baellor House (CILA)	Wiggins House (CILA)
Richard L. Grader	100,250	19,047	18,045	21,052	22,055	5,012	5,012	5,012	5,012

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

10/1/24 - 9/30/25

#0037341

Owners' Compensation
10/1/24 - 9/30/25

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

Richard L. Grader:

- | | | |
|---------------------------------------|----------------------------------|---|
| 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.

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2025
The group consists of four DD homes (16 beds each) and four CILA homes (10 beds)
All costs of the central office and common costs are allocated as follows:
Carlinville -19%, Emerald - 18%, Marigold - 21%, Patterson - 22%, CILA's - 20%

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	2,161	411	389	454	475	432	1
Housekeeping Supplies	945	180	170	198	208	189	3
Utilities	19,457	3,697	3,502	4,086	4,281	3,891	5
Maintenance	35,099	6,669	6,318	7,371	7,722	7,020	6
Nursing	4,945	940	890	1,038	1,088	989	10
Activities Supplies	35	7	6	7	8	7	11
Administrative Salaries	300,859	57,163	54,155	63,180	66,189	60,172	17
Professional Services	22,801	4,332	4,104	4,788	5,016	4,560	19
Dues, Fees and Subscriptions	3,053	580	549	641	672	611	20
Contributions	500	95	90	105	110	100	20
Office Supplies	7,115	1,352	1,281	1,494	1,565	1,423	21
Other Office Expense	9,286	1,764	1,671	1,950	2,043	1,857	21
Postage	374	71	67	78	82	75	21
Telephone	9,815	1,865	1,767	2,061	2,159	1,963	21
Payroll Taxes	22,641	4,302	4,075	4,755	4,981	4,528	22
Group Health Insurance	74,187	14,096	13,354	15,579	16,321	14,837	22
Workers Comp Insurance	28,576	5,429	5,144	6,001	6,287	5,715	22
Business Meals	1,169	222	210	246	257	234	22
Entertainment	-	-	-	-	-	-	22
Other Employee Benefits	5,126	974	923	1,076	1,128	1,025	22
Inservice Training & Education	8,243	1,566	1,484	1,731	1,813	1,649	23
Travel & Seminars	-	-	-	-	-	-	24
Other Admin/Staff Transportation	41,455	7,876	7,462	8,706	9,120	8,291	25
Insurance	63,490	12,063	11,428	13,333	13,968	12,698	26
Depreciation	16,268	3,091	2,928	3,416	3,579	3,254	30
Interest Inc/Expense	(14,778)	(2,808)	(2,660)	(3,103)	(3,251)	(2,956)	32
Real Estate Taxes	11,389	2,164	2,050	2,392	2,505	2,278	33
Lease - Central Office	30,000	5,700	5,400	6,300	6,600	6,000	34
IL replacement tax	28,500	5,415	5,130	5,985	6,270	5,700	36
TOTALS	<u>732,711</u>	<u>139,215</u>	<u>131,888</u>	<u>153,869</u>	<u>161,196</u>	<u>146,542</u>	

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

#0037341

10/1/24 - 9/30/25

Page 9, Part IX

Mortgage

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

Balance @ 9/30/25	446,833
Carlinville Estates	84,898
Emerald Estates	80,430
Marigold Estates	93,835
Patterson House	98,303

Patterson House, Inc.	10/1/24- 9/30/2025
Patterson House	#0037341

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	65,631
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Line 28, Other Revenue

Social Security	-
Earning Credits	23,956
Residents' travel reimbursement	8,873
Miscellaneous income	348
Workshop	329,485
	<u>362,662</u>

**Facility fiscal year end is 9/30/25, tax year end is 12/31/25.
Taxable income will not agree.

Patterson House, Inc.

10/1/24 - 9/30/25

Patterson House

#0037341

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.

Patterson House, Inc.
Patterson House #0037341 10/1/24 - 9/30/25

Page 3, Part V

Line 25, Other Admin Staff Transportation

Vehicle expense	3,469
Vehicle fuel	4,616
Mileage	<u>23,519</u>
	<u><u>31,604</u></u>