

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0037341

Facility Name: Patterson House

Address: 307 East Jefferson Sullivan 61951
 Number City Zip Code

County: Moultrie

Telephone Number: 217-728-4357 Fax # ()

HFS ID Number: 37-1281054

Date of Initial License for Current Owners: 2/11/92

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
 Name: W.R. Moss, CPA Telephone Number: 217-875-2655

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/04 to 09/30/05 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) <u>Daniel P. Caulkins</u>	
	(Title) <u>President</u>	
Paid Preparer	(Signed) <u>See Attached Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>William R. Moss, CPA</u>	
	(Firm Name & Address) <u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Rd, Decatur, IL 62526</u>	
	(Telephone) <u>217-875-2655</u> Fax # <u>217-875-1660</u>	

**MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

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>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 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>5,253</u>			<u>5,253</u>	13
14	TOTALS	<u>5,253</u>			<u>5,253</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.95%

D. How many bed-hold days during this year were paid by the Department? 106 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 11/15/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 9/30/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	28,162	1,440	2,316	31,918		31,918	31,918		1	
2	Food Purchase		31,956		31,956	(3,650)	28,306	28,306		2	
3	Housekeeping	16,640	3,986	468	21,094		21,094	21,094		3	
4	Laundry	10,893	698	30	11,621		11,621	11,621		4	
5	Heat and Other Utilities			13,922	13,922		13,922	13,922		5	
6	Maintenance		1,420	19,499	20,919		20,919	20,919		6	
7	Other (specify):*									7	
8	TOTAL General Services	55,695	39,500	36,235	131,430	(3,650)	127,780	127,780		8	
	B. Health Care and Programs										
9	Medical Director			3,900	3,900		3,900	(300)	3,600	9	
10	Nursing and Medical Records	112,014	998	10,406	123,418		123,418	123,418		10	
10a	Therapy			330	330		330	330		10a	
11	Activities	25,224	2,934	2,889	31,047		31,047	31,047		11	
12	Social Services	18,022		1,558	19,580		19,580	19,580		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	155,260	3,932	19,083	178,275		178,275	(300)	177,975	16	
	C. General Administration										
17	Administrative	84,069			84,069		84,069	84,069		17	
18	Directors Fees									18	
19	Professional Services			7,089	7,089		7,089	7,089		19	
20	Dues, Fees, Subscriptions & Promotions			2,001	2,001		2,001	(1,166)	835	20	
21	Clerical & General Office Expenses		5,461	4,322	9,783		9,783	9,783		21	
22	Employee Benefits & Payroll Taxes			48,186	48,186	3,650	51,836	51,836		22	
23	Inservice Training & Education			86	86		86	86		23	
24	Travel and Seminar			573	573		573	(573)		24	
25	Other Admin. Staff Transportation			12,523	12,523	(1,548)	10,975	10,975		25	
26	Insurance-Prop.Liab.Malpractice			20,241	20,241		20,241	20,241		26	
27	Other (specify):*									27	
28	TOTAL General Administration	84,069	5,461	95,021	184,551	2,102	186,653	(1,739)	184,914	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	295,024	48,893	150,339	494,256	(1,548)	492,708	(2,039)	490,669	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,310	12,310		12,310	622	12,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,524	8,524		8,524		8,524			32
33	Real Estate Taxes			8,276	8,276		8,276		8,276			33
34	Rent-Facility & Grounds			1,950	1,950		1,950		1,950			34
35	Rent-Equipment & Vehicles			10,214	10,214		10,214		10,214			35
36	Other (specify):*											36
37	TOTAL Ownership			41,274	41,274		41,274	622	41,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,548	1,548		1,548			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,833	38,833		38,833		38,833			42
43	Other (specify):* State Income Tax			772	772		772	(772)				43
44	TOTAL Special Cost Centers			39,605	39,605	1,548	41,153	(772)	40,381			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	295,024	48,893	231,218	575,135		575,135	(2,189)	572,946			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/04

Ending:

09/30/05

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				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				15
16	Personal Expenses (Including Transportation)	(573)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(603)	20		19
20	Contributions	(563)	20		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	(772)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	322			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,189)		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,189)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 1,548	25	38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,548		47

OHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House

ID# 0037341
 Report Period Beginning: 10/01/04
 Ending: 09/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Depreciation-Central Office	\$ 2,943	30	1
2	Depreciation Adjustment	(2,321)	30	2
3	Medical Dir--to get 12 payments	(300)	9	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	322		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/04

Ending:

09/30/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	(300)	0	0	0	0	0	0	0	0	0	0	(300)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(300)	0	0	0	0	0	0	0	0	0	0	(300)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,166)	0	0	0	0	0	0	0	0	0	0	(1,166)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(573)	0	0	0	0	0	0	0	0	0	0	(573)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,739)	0	0	0	0	0	0	0	0	0	0	(1,739)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,039)	0	0	0	0	0	0	0	0	0	0	(2,039)	29

STATE OF ILLINOIS

Facility Name & ID Number Patterson House# 0037341

Report Period Beginning:

10/01/04

Ending:

Summary B

09/30/05

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	622	0	0	0	0	0	0	0	0	0	0	622 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	622	0	0	0	0	0	0	0	0	0	0	622 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):*	(772)	0	0	0	0	0	0	0	0	0	0	(772) 43
44	TOTAL Special Cost Centers	(772)	0	0	0	0	0	0	0	0	0	0	(772) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,189)	0	0	0	0	0	0	0	0	0	0	(2,189) 45

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard Grader	50	Patterson House	Sullivan	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Carlville Estates	Carlville			
		Emerald Estates	Canton			
		Marigold Estates	Pekin			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

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	50.00	See	10	25.00	Wages	\$ 32,253	17.1	1
2	Daniel P. Caulkins	Vice President	Administration	50.00	Attached	10	25.00	Wages	32,253	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,506		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

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

Name of Related Organization Central Office-Patterson House
 Street Address 120 East Cerro Gordo
 City / State / Zip Code Decatur, IL 62525
 Phone Number (217-422-6510
 Fax Number (217-422-6819

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

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	Regions Bank & Trust		X	Mortgage	\$3,600.00	10/27/03	\$ 200,399	\$ 148,169	9/28/08	5.0000	\$ 7,996	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Regions Bank & Trust		X	Working Capital		12/01/03			12/1/04		528	6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,600.00		\$ 200,399	\$ 148,169			\$ 8,524	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 200,399	\$ 148,169			\$ 8,524	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 4,910	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.)		\$ 8,276	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,366	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 4,910	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.		\$ 8,276	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	7,840	8
	2001	7,713	9
	2002	7,846	10
	2003	7,890	11
	2004	8,276	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Patterson House COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0037341

CONTACT PERSON REGARDING THIS REPORT W.R. Moss, CPA

TELEPHONE 217-875-2655 FAX #: 217-875-1660

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2004

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 08-08-01-311-002	NE 1/4 & E 1/2 NW 1/4 Blk 7	\$ 8,276.03	\$ 8,276.06
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>8,276.03</u>	\$ <u>8,276.06</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Patterson House

0037341 Report Period Beginning:

10/01/04 Ending:

09/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,900 B. General Construction Type: Exterior Brick-metal siding 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).

None

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	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>15,000</u>	<u>1990</u>	<u>\$ 16,205</u>	1
2					2
3	TOTALS	15,000		\$ 16,205	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Patterson House**

0037341

Report Period Beginning:

10/01/04

Ending:

09/30/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	\$ 233,435	\$ 5,836	40	\$ 5,836	\$	\$ 81,217	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Driveway		10/15/1991	16,709		10			16,709	9
10		Landscaping		10/15/1991	4,593		10			4,593	10
11		Fire equipment		2/25/1993	1,592		10			1,592	11
12		Carpet replacement		7/27/1998	2,759		5			2,759	12
13		Electrical work		1/23/1998	466		10	47	47	346	13
14		Electrical system & alarm system improvements		4/1/1998	3,445		5			3,445	14
15		Fire protection system improvements		4/1/1998	698		5			698	15
16		Carpet replacement		8/23/2000	2,810		5	515	515	2,810	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/04 Ending:

09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$ 266,507	\$ 5,836		\$ 6,398	\$ 562	\$ 114,169	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 76,321	\$ 3,929	\$ 3,270	\$ (659)		\$ 69,371	71
72	Current Year Purchases	5,072		719	719		719	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 81,393	\$ 3,929	\$ 3,989	\$ 60		\$ 70,090	75

D. Vehicle Depreciation (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	Administration	2003 Cadillac Escalade	11/20/2003	\$ 12,724	\$ 2,545	\$ 2,545		5	\$ 4,666	76
77										77
78										78
79										79
80	TOTALS			\$ 12,724	\$ 2,545	\$ 2,545			\$ 4,666	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)	\$ 376,829	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,310	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,932	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 622	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 188,925	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Central Office--See attached schedule

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	<u>See attached</u>		\$	\$ <u>10,214</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 10,214	21

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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 prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/04 Ending: 09/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/05 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 100	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	145,649	530,793	3
4	Supply Inventory (priced at <u>cost</u>)	1,405	4,541	4
5	Short-Term Investments			5
6	Prepaid Insurance		33,139	6
7	Other Prepaid Expenses	707	4,947	7
8	Accounts Receivable (owners or related parties)	56	150,884	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 147,917	\$ 724,804	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	16,205	20,550	13
14	Buildings, at Historical Cost	257,586	257,586	14
15	Leasehold Improvements, at Historical Cost	2,810	125,948	15
16	Equipment, at Historical Cost	71,217	332,804	16
17	Accumulated Depreciation (book methods)	(163,565)	(362,804)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,232	10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,232)	(599,283)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>		746,683	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 184,253	\$ 531,716	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 332,170	\$ 1,256,520	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 97,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(453)		28
29	Short-Term Notes Payable		159,000	29
30	Accrued Salaries Payable		42,175	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,966	39,193	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,201	25,611	32
33	Accrued Interest Payable		2,444	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Sundry</u>	14,964	57,000	36
37	<u>Intercompany account</u>	(409,693)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (377,015)	\$ 423,037	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		30,089	39
40	Mortgage Payable	148,169	526,294	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)	\$ 148,169	\$ 556,383	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (228,846)	\$ 979,420	46
47	TOTAL EQUITY (page 18, line 24)	\$ 561,016	\$ 277,100	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 332,170	\$ 1,256,520	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 519,671	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 519,671	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	92,540	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	(51,195)	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)	\$ 41,345	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)	\$ 561,016	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/01/04

Ending:

09/30/05

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 651,498	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 651,498	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	13,417	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,417	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,212	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,212	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Reimburse resident's travel	1,548	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,548	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 667,675	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	131,430	31
32	Health Care	178,275	32
33	General Administration	184,551	33
B. Capital Expense			
34	Ownership	41,274	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,833	36
D. Other Expenses (specify):			
37	State income tax	772	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 575,135	40
41	Income before Income Taxes (line 30 minus line 40)**	92,540	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 92,540	43

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

Tax return
is cash basis
calendar year.

** 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/04

Ending:

09/30/05

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	13,078	13,178	112,014	8.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,080	25,224	12.13	9
10	Activity Assistants					10
11	Social Service Workers	1,213	1,293	18,022	13.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,200	1,240	12,400	10.00	14
15	Cook Helpers/Assistants	1,609	1,659	15,762	9.50	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,910	1,958	16,640	8.50	18
19	Laundry	1,225	1,281	10,893	8.50	19
20	Administrator	500	520	13,692	26.33	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	64,506	62.03	22
23	Office Manager					23
24	Clerical	500	520	5,871	11.29	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)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,275	24,769	\$ 295,024 *	\$ 11.91	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	50	\$ 2,316	1.3	35
36	Medical Director	36	3,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	150	4,491	10.3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	5	265	10a.3	40
41	Occupational Therapy Consultant	2	65	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	39	1,691	10.3	43
44	Activity Consultant	6	258	11.3	44
45	Social Service Consultant	38	1,558	12.3	45
46	Other(specify) <u>Psychologist</u>	16	881	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	342	\$ 15,125		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/01/04

Ending: 09/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jacqueline Danneberger	Offc. Assistant	0	\$ 5,871	Workers' Compensation Insurance	\$ 8,519	IDPH License Fee	\$ 100	
Richard L. Grader	Administrative	50	32,253	Unemployment Compensation Insurance	2,928	Advertising: Employee Recruitment	41	
Daniel P. Caulkins	Administrative	50	32,253	FICA Taxes	21,077	Health Care Worker Background Check		
Lori Dillman	Administrator	0	13,692	Employee Health Insurance	14,506	(Indicate # of checks performed)		
				Employee Meals	3,650	Dues, subs, sundry	694	
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Physicals	254			
				Sundry	902			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 84,069					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Chamblin, Moss & Moore	CPA		\$ 6,280				Out-of-State Travel	\$
May, Cocagne & King, P.C.	CPA		250					
Duane Morris	Attorney		147				In-State Travel	
Samuels Miller, etc	Attorney		412					
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 7,089				TOTAL	\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Patterson House

Report Period Beginning: 10/01/04 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting	7/99	1,700	5	340	340	255	28				
3	Electric	9/99	670	5	134	134	134					
4	Painting	1/04	3,500	5			467	700				
5	Painting	2/04	3,990	5			466	798				
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 9,860		\$ 474	\$ 474	\$ 1,322	\$ 1,526	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? 5 yr
- (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. \$ 38,833
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? No 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. \$ 3,650 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,548
- 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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House, Inc.
Carlinsville Estates
Emerald Estates
Marigold Estates

Allocation of Central Office Costs
Year Ended September 30, 2005

The group consists of four DD homes - All with 16 beds.

All costs of the central office and common costs are allocated 25% to each facility

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

	Total Expense	Carlinsville 25%	Emerald 25%	Marigold 25%	Patterson House 25%	Line Ref
Professional fees	27,638	6,910	6,910	6,910	6,910	19
Donations	1,325	331	331	331	331	20
Postage	1,756	439	439	439	439	21
Telephone	9,570	2,393	2,393	2,393	2,393	21
Utilities - Central Office	902	225	225	225	225	5
Group Insurance	38,602	9,651	9,651	9,651	9,651	22
Workers Comp Insurance	27,097	6,774	6,774	6,774	6,774	22
General Insurance	60,248	15,062	15,062	15,062	15,062	26
Business Meals	2,048	512	512	512	512	20
Depreciation	11,774	2,944	2,944	2,944	2,944	30
Interest expense	34,483	8,621	8,621	8,621	8,621	32
Lease Expense - Central Office	7,800	1,950	1,950	1,950	1,950	34
Rent - Vehicles	9,963	2,491	2,491	2,491	2,491	35
State Income Tax Expense	3,088	772	772	772	772	43
	<u>236,295.73</u>	<u>59,073.93</u>	<u>59,073.93</u>	<u>59,073.93</u>	<u>59,073.93</u>	

PATTERSON HOUSE

PAGE 3, LINE 25

September 30, 2005

Fuel and repairs for the facility vehicles	9,061
Reimbursement of employee, care-related local travel	<u>3,462</u>
	<u>12,523</u>
Less: Allocation to page 4, line 38	<u>(1,548)</u>
	<u><u>10,975</u></u>

PATTERSON HOUSE

PAGE 14, PART XII, C

VEHICLE RENTAL

<u>USE</u>	<u>Model Year and Make</u>	<u>Monthly Lease Payment</u>	<u>Rental Expense for Period</u>
Resident Transportation	2003 Ford E 350	644	7,724
Administration	2001 Lexus	<u>208</u>	<u>2,491</u>
	TOTAL	851	10,215

PATTERSON HOUSE

VEHICLE LEASES--CENTRAL OFFICE

September 30, 2005

The company leases a vehicle which is used for care-related activities. The lease payments are paid by the central office and allocated 25 % to each facility.

2001 Lexus-used for facility business-Leased September, 2001.

The lease expense is as follows:

	<u>2001 Lexus</u>
Monthly Payment	830
# of Months	<u>12</u>
	9,960
	<u>x 25%</u>
Facility allocation	2,490

CARLINVILLE ESTATES
EMERALD ESTATES
MARIGOLD ESTATES
PATTERSON HOUSE

RENT

9/30/2005

The Central Office leases an office in Decatur, Illinois, from which all corporate business is transacted, records are stored, and the administrative staff operates. The rent is \$650 per month, which is split \$162.50 to each facility.

The landlord is not a related party.

PATTERSON HOUSE, INC.

OFFICERS COMPENSATION

September 30, 2005

	<u>TOTAL COMP</u>	<u>CARLINVILLE ESTATES</u>	<u>EMERALD ESTATES</u>	<u>MARIGOLD ESTATES</u>	<u>PATTERSON HOUSE</u>
Richard L. Grader	129,012	32,253	32,253	32,253	32,253
Daniel P. Caulkins	<u>129,012</u>	<u>32,253</u>	<u>32,253</u>	<u>32,253</u>	<u>32,253</u>
	<u>258,024</u>	<u>64,506</u>	<u>64,506</u>	<u>64,506</u>	<u>64,506</u>

PATTERSON HOUSE

OWNER'S COMPENSATION

September 30, 2005

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

Richard L. Grader

- Purchasing
- Approving vendors
- Reviewing vendor invoices
- Paying invoices
- Reviewing public aid billings
- Reviewing accounts receivable
- Following up on billing discrepancies
- Managing cash flow
- Negotiating with bank
- Bookkeeping
- All financial management functions

Daniel P. Caulkins

- Operations of the facility
- Supervising employees
- Dealing with consultants
- Buying supplies
- Inspecting the facility
- Locating residents
- Dealing with resident families
- Dealing with government agencies

Both owners

- Dealing with local day program agency
- Attending employee meetings
- Recruiting employees
- Dealing with employee complaints
- Performing employee duties when the employee does not report to work

The above duties are not all encompassing. Like all small business owners, the owners work many hours on many different types of duties.