



Facility Name & ID Number Patterson House

# 0037341 Report Period Beginning: 10/01/05 Ending: 09/30/06

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>5,499</u>			<u>5,499</u>	13
14	TOTALS	<u>5,499</u>			<u>5,499</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.16%

D. How many bed-hold days during this year were paid by the Department?

151 (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: 12/31/06 Fiscal Year: 09/30/06

\* 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: 10/01/05 Ending: 09/30/06

**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
	<b>A. General Services</b>										
1	Dietary	29,520	2,083	1,710	33,313		33,313	33,313		1	
2	Food Purchase		30,242		30,242	(3,650)	26,592	26,592		2	
3	Housekeeping	18,512	4,473	854	23,839		23,839	23,839		3	
4	Laundry	9,442	680	404	10,526		10,526	10,526		4	
5	Heat and Other Utilities			14,634	14,634		14,634	14,634		5	
6	Maintenance		1,640	16,140	17,780		17,780	17,780		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	<b>57,474</b>	<b>39,118</b>	<b>33,742</b>	<b>130,334</b>	<b>(3,650)</b>	<b>126,684</b>	<b>126,684</b>		<b>8</b>	
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,900	3,900		3,900	(300)	3,600	9	
10	Nursing and Medical Records	96,153	4,980	5,573	106,706		106,706	106,706		10	
10a	Therapy			609	609		609	609		10a	
11	Activities	24,133	2,876	2,405	29,414		29,414	29,414		11	
12	Social Services	30,095		1,631	31,726		31,726	31,726		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	<b>150,381</b>	<b>7,856</b>	<b>14,118</b>	<b>172,355</b>		<b>172,355</b>	<b>(300)</b>	<b>172,055</b>	<b>16</b>	
	<b>C. General Administration</b>										
17	Administrative	100,675			100,675		100,675	100,675		17	
18	Directors Fees									18	
19	Professional Services			10,919	10,919		10,919	10,919		19	
20	Dues, Fees, Subscriptions & Promotions			4,908	4,908		4,908	(4,129)	779	20	
21	Clerical & General Office Expenses		7,231	4,671	11,902		11,902	1,379	13,281	21	
22	Employee Benefits & Payroll Taxes			44,070	44,070	3,650	47,720		47,720	22	
23	Inservice Training & Education			173	173		173		173	23	
24	Travel and Seminar			150	150		150	(150)		24	
25	Other Admin. Staff Transportation			9,813	9,813		9,813		9,813	25	
26	Insurance-Prop.Liab.Malpractice			20,846	20,846		20,846		20,846	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	<b>100,675</b>	<b>7,231</b>	<b>95,550</b>	<b>203,456</b>	<b>3,650</b>	<b>207,106</b>	<b>(2,900)</b>	<b>204,206</b>	<b>28</b>	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>308,530</b>	<b>54,205</b>	<b>143,410</b>	<b>506,145</b>		<b>506,145</b>	<b>(3,200)</b>	<b>502,945</b>	<b>29</b>	

\*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	
	<b>D. Ownership</b>											
30	Depreciation			18,255	18,255		18,255	(5,835)	12,420			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,660	13,660		13,660		13,660			32
33	Real Estate Taxes			8,473	8,473		8,473		8,473			33
34	Rent-Facility & Grounds			1,950	1,950		1,950		1,950			34
35	Rent-Equipment & Vehicles			12,096	12,096		12,096		12,096			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			54,434	54,434		54,434	(5,835)	48,599			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,083	41,083		41,083		41,083			42
43	Other (specify):* <b>State Income Tax</b>			1,127	1,127		1,127	(1,127)				43
44	<b>TOTAL Special Cost Centers</b>			42,210	42,210		42,210	(1,127)	41,083			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	308,530	54,205	240,054	602,789		602,789	(10,162)	592,627			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:

10/01/05

Ending:

09/30/06

**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)	(150)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(496)	20		19
20	Contributions	(3,633)	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	(1,127)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,756)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (10,162)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (10,162)		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	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House

ID# 0037341

Report Period Beginning: 10/01/05

Ending: 09/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Depreciation - Central Office	\$ 414	30	1
2	Depreciation Adjustment	(6,249)	30	2
3	Medical Director - to get 12 payments	(300)	9	3
4	Office supplies	1,379	21	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	<b>Total</b>	(4,756)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning:

10/01/05

Ending:

09/30/06

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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	(300)	0	0	0	0	0	0	0	0	0	0	(300)	16
	<b>C. General Administration</b>													
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	(4,129)	0	0	0	0	0	0	0	0	0	0	(4,129)	20
21	Clerical & General Office Expenses	1,379	0	0	0	0	0	0	0	0	0	0	1,379	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	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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	<b>TOTAL General Administration</b>	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(3,200)	0	0	0	0	0	0	0	0	0	0	(3,200)	29

STATE OF ILLINOIS

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning:

10/01/05

Ending:

Summary B

09/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(5,835)	0	0	0	0	0	0	0	0	0	0	(5,835)	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	<b>TOTAL Ownership</b>	<b>(5,835)</b>	<b>0</b>	<b>(5,835)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(1,127)	0	0	0	0	0	0	0	0	0	0	(1,127)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,127)</b>	<b>0</b>	<b>(1,127)</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(10,162)</b>	<b>0</b>	<b>(10,162)</b>	<b>45</b>									

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning:

10/01/05

Ending:

09/30/06

**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: 10/01/05 Ending: 09/30/06

## 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	\$ 40,720	17.1	1
2	Daniel P. Caulkins	Vice President	Administration	50.00	Attached	10	25.00	Wages	40,720	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	\$ 81,440		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: 10/01/05 Ending: 09/30/06

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

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		<b>A. Directly Facility Related</b>										
<b>Long-Term</b>												
1	Regions Bank & Trust		X	Mortgage	\$3,600.00	10/27/03	\$ 200,399	\$ 108,504	09/28/08	5.0000	\$ 9,165	1
2												2
3												3
4												4
5												5
<b>Working Capital</b>												
6	Regions Bank & Trust		X	Working Capital		12/01/03					4,497	6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$3,600.00		\$ 200,399	\$ 108,504			\$ 13,662	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 200,399	\$ 108,504			\$ 13,662	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><b>Important</b>, 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 2005 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.)		\$ 8,473	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,563	3
4. Real Estate Tax accrual used for 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 8,473	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	7,713	8
	2002	7,846	9
	2003	7,890	10
	2004	8,276	11
	2005	8,473	12
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

**2005 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 2005 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 200!

(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	\$ 8,473.14	\$ 8,473.14
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>8,473.14</u>	\$ <u>8,473.14</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

**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.

Facility Name & ID Number Patterson House

# 0037341 Report Period Beginning:

10/01/05 Ending:

09/30/06

**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	<b>TOTALS</b>	<b>15,000</b>		<b>\$ 16,205</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Patterson House**

# **0037341**

Report Period Beginning:

**10/01/05**

Ending:

**09/30/06**

**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	\$	\$ 87,053	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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	393	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			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:

10/01/05

Ending:

09/30/06

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	\$	5,883	\$	47	\$	120,052	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: 10/01/05 Ending: 09/30/06

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	\$ 81,393	\$ 9,363	\$ 3,482	\$ (5,881)		\$ 73,572	71
72	Current Year Purchases	20,374	3,056	3,056			3,056	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 101,767	\$ 12,419	\$ 6,538	\$ (5,881)		\$ 76,628	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 384,479	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,255	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,421	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,834)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 196,680	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	<b>TOTAL</b>				\$			7

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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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>12,096</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <b>12,096</b>	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.

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)	
<b>TOTAL TRAINED</b>	

- (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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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	<b>TOTAL</b>			\$		\$	\$		\$	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: 10/01/05 Ending: 09/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,309	\$ 9,387	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	103,145	367,208	3
4	Supply Inventory (priced at <u>Cost</u> )	1,405	4,541	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	525	2,100	7
8	Accounts Receivable (owners or related parties)	49,278	196,650	8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 156,662	\$ 579,886	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,292	20,550	13
14	Buildings, at Historical Cost	257,586	257,586	14
15	Leasehold Improvements, at Historical Cost	2,810	125,947	15
16	Equipment, at Historical Cost	114,739	357,349	16
17	Accumulated Depreciation (book methods)	(195,014)	(413,666)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,232	10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,232)	(649,064)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>		746,682	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 197,413	\$ 455,616	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 354,075	\$ 1,035,502	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 42,801	\$ 171,202	26
27	Officer's Accounts Payable	1,150	4,600	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	27,500	110,000	29
30	Accrued Salaries Payable	10,508	42,029	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,869	41,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,201	25,611	32
33	Accrued Interest Payable		2,445	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Interco Account</u>	(441,269)		36
37	<u>Sundry</u>	(116)	10,093	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ (338,356)	\$ 407,846	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	5,220	20,880	39
40	Mortgage Payable	108,505	439,321	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 113,725	\$ 460,201	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ (224,631)	\$ 868,047	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 576,706	\$ 167,455	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 352,075	\$ 1,035,502	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 561,016	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 561,016	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	74,356	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(58,666)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 15,690</b>	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 576,706</b>	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning: 10/01/05

Ending:

09/30/06

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 634,030	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 634,030</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	25,391	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 25,391</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,191	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,191</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached schedule</u>	16,533	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 16,533</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 677,145</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	130,334	31
32	Health Care	172,355	32
33	General Administration	203,456	33
<b>B. Capital Expense</b>			
34	Ownership	54,434	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	41,083	36
<b>D. Other Expenses (specify):</b>			
37	<u>State Income Tax</u>	1,127	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 602,789</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>74,356</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 74,356</b>	43

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

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

Tax return is cash basis calendar year.

\*\*\* 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:

10/01/05

Ending:

09/30/06

**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	11,885	11,885	96,153	8.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,690	2,690	24,133	8.97	9
10	Activity Assistants					10
11	Social Service Workers	2,303	2,303	30,095	13.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,095	2,095	21,308	10.17	14
15	Cook Helpers/Assistants	1,046	1,046	8,212	7.85	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,080	2,080	18,512	8.90	18
19	Laundry	1,167	1,167	9,442	8.09	19
20	Administrator	500	520	13,270	25.52	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	81,440	78.31	22
23	Office Manager					23
24	Clerical	500	520	5,965	11.47	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)	25,266	25,346	\$ 308,530 *	\$ 12.17	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	36	\$ 1,710	1.3	35
36	Medical Director	39	3,900	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	105	3,160	10.3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6	188	10a.3	40
41	Occupational Therapy Consultant	9	421	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	36	1,644	10.3	43
44	Activity Consultant	53	2,405	11.3	44
45	Social Service Consultant	47	1,631	12.3	45
46	Other(specify) <u>Psychologist</u>	15	769	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	346	\$ 15,828		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

**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	\$ 5,965	Workers' Compensation Insurance	\$ 7,182	IDPH License Fee	\$ 100	
Richard L. Grader	Administrative	50	40,720	Unemployment Compensation Insurance	5,222	Advertising: Employee Recruitment	93	
Daniel P. Caulkins	Administrative	50	40,720	FICA Taxes	20,847	Health Care Worker Background Check		
Lori Dillman	Administrator	0	13,270	Employee Health Insurance	9,084	(Indicate # of checks performed)		
				Employee Meals	3,650	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues, subs, sundry	586	
				Employee Physicals	612			
				Dues, subs, sundry	1,123			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 100,675					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount						
May, Cocagne & King, P.C.	CPA	\$ 7,892						
Duane Morris	Attorney	3,027						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 10,919					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Patterson House

Report Period Beginning: 10/01/05 Ending: 09/30/06

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting	01/04	\$ 3,500	5	\$	\$ 467	\$ 700	\$ 700	\$	\$	\$	\$	\$
2	Painting	02/04	3,990	5		466	798	798					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 7,490		\$	\$ 933	\$ 1,498	\$ 1,498	\$	\$	\$	\$	\$

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? 5YR
- (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. \$ 41,083  
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. \$ 0  
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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Patterson House, Inc.  
 Carlenville Estates  
 Emerald Estates  
 Marigold Estates**

**Allocation of Central Office Costs  
 Year Ended September 30, 2006**

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	Carlenville 25%	Emerald 25%	Marigold 25%	Patterson House 25%	Line Ref
Professional fees	31,568	7,892	7,892	7,892	7,892	19
Donations	4,928	1,232	1,232	1,232	1,232	20
Postage	2,467	617	617	617	617	21
Telephone	12,850	3,213	3,213	3,213	3,213	21
Utilities - Central Office	1,367	342	342	342	342	5
Group Insurance	36,335	9,084	9,084	9,084	9,084	22
Workers Comp Insurance	28,728	7,182	7,182	7,182	7,182	22
General Insurance	86,110	21,528	21,528	21,528	21,528	26
Business Meals	871	218	218	218	218	20
Depreciation	1,656	414	414	414	414	30
Interest expense	11,638	2,910	2,910	2,910	2,910	32
Lease Expense - Central Office	7,800	1,950	1,950	1,950	1,950	34
Rent - Vehicles	18,140	4,535	4,535	4,535	4,535	35
State Income Tax Expense	4,507	1,127	1,127	1,127	1,127	43
	<u>248,965.00</u>	<u>62,241.25</u>	<u>62,241.25</u>	<u>62,241.25</u>	<u>62,241.25</u>	

The 2003 Cadillac Escalade was converted to personal use in January 2006.

PATTERSON HOUSE

PAGE 3, LINE 25

September 30, 2006

Fuel and repairs for the facility vehicles	3,707
Reimbursement of employee, care-related local travel	<u>6,106</u>
	<u>9,813</u>
Less: Allocation to page 4, line 38	<u>-</u>
	<u><u>9,813</u></u>

PATTERSON HOUSE

PAGE 14, PART XII, C

VEHICLE RENTAL

USE	Model Year and Make	Monthly Lease Payment	Rental Expense for Period
Resident Transportation	2003 Ford E 350	630	7,560
Administration	2005 Lexus	216	2,590
	2006 Lexus	216	1,945
	TOTAL	1,062	12,095

PATTERSON HOUSE

VEHICLE LEASES--CENTRAL OFFICE

September 30, 2006

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

2005 Lexus-used for facility business-Leased September, 2005.

2006 Lexus-used for facility business-Leased January, 2006.

The lease expense is as follows:

	2005 Lexus	2006 Lexus
Monthly Payment	863	865
# of Months	12	9
	10,361	7,781
	x 25%	x 25%
Facility allocation	2,590	1,945

CARLINVILLE ESTATES  
EMERALD ESTATES  
MARIGOLD ESTATES  
PATTERSON HOUSE

RENT

9/30/2006

The central office leases an office in Decatur, Illinois, from which 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, 2006

	<u>TOTAL COMP</u>	<u>CARLINVILLE ESTATES</u>	<u>EMERALD ESTATES</u>	<u>MARIGOLD ESTATES</u>	<u>PATTERSON HOUSE</u>
Richard L. Grader	162,880	40,720	40,720	40,720	40,720
Daniel P. Caulkins	<u>162,880</u>	<u>40,720</u>	<u>40,720</u>	<u>40,720</u>	<u>40,720</u>
	<u>325,760</u>	<u>81,440</u>	<u>81,440</u>	<u>81,440</u>	<u>81,440</u>

PATTERSON HOUSE

OWNER'S COMPENSATION

September 30, 2006

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.

PATTERSON HOUSE

OTHER REVENUE

September 30, 2006

Page 19 Section E

Earning credits	8,804
Miscellaneous	1,089
Vehicle Lease	<u>6,640</u> ***
	<u><u>16,533</u></u>

\*\*\* Shareholder reimbursed to corporation for use of Escalade - not on cost report depreciation schedules.