

Facility Name & ID Number Patterson House

0037341 Report Period Beginning: 10/01/06 Ending: 09/30/07

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,261			5,261
14	TOTALS	5,261			5,261

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.09%

D. How many bed-hold days during this year were paid by the Department? 79 (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: 12/31/07 Fiscal Year: 09/30/07

* 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: 10/01/06 Ending: 09/30/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	30,247	1,720	1,561	33,528		33,528		33,528		1
2	Food Purchase		29,988		29,988	(3,650)	26,338		26,338		2
3	Housekeeping	18,512	5,054	248	23,814		23,814		23,814		3
4	Laundry	9,783	2,879		12,662		12,662		12,662		4
5	Heat and Other Utilities			14,862	14,862		14,862		14,862		5
6	Maintenance		3,604	12,697	16,301		16,301		16,301		6
7	Other (specify):*										7
8	TOTAL General Services	58,542	43,245	29,368	131,155	(3,650)	127,505		127,505		8
	B. Health Care and Programs										
9	Medical Director			3,900	3,900		3,900	(300)	3,600		9
10	Nursing and Medical Records	99,047	4,331	6,446	109,824		109,824		109,824		10
10a	Therapy			66	66		66		66		10a
11	Activities	25,618	4,508	3,394	33,520		33,520		33,520		11
12	Social Services	30,489		915	31,404		31,404		31,404		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	155,154	8,839	14,721	178,714		178,714	(300)	178,414		16
	C. General Administration										
17	Administrative	77,596			77,596		77,596		77,596		17
18	Directors Fees										18
19	Professional Services			7,702	7,702		7,702		7,702		19
20	Dues, Fees, Subscriptions & Promotions			2,000	2,000		2,000	(878)	1,122		20
21	Clerical & General Office Expenses		6,449	4,836	11,285		11,285		11,285		21
22	Employee Benefits & Payroll Taxes			55,461	55,461	3,650	59,111		59,111		22
23	Inservice Training & Education			406	406		406		406		23
24	Travel and Seminar			200	200		200	(200)			24
25	Other Admin. Staff Transportation			13,894	13,894	(1,153)	12,741		12,741		25
26	Insurance-Prop.Liab.Malpractice			11,902	11,902		11,902		11,902		26
27	Other (specify):*										27
28	TOTAL General Administration	77,596	6,449	96,401	180,446	2,497	182,943	(1,078)	181,865		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	291,292	58,533	140,490	490,315	(1,153)	489,162	(1,378)	487,784		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.

Facility Name & ID Number

Patterson House

#0037341

Report Period Beginning:

10/01/06

Ending:

09/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,216	15,216		15,216	(2,400)	12,816			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,053	21,053		21,053		21,053			32
33	Real Estate Taxes			8,406	8,406		8,406		8,406			33
34	Rent-Facility & Grounds			1,950	1,950		1,950		1,950			34
35	Rent-Equipment & Vehicles			12,673	12,673		12,673		12,673			35
36	Other (specify):*											36
37	TOTAL Ownership			59,298	59,298		59,298	(2,400)	56,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,153	1,153		1,153			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,286	39,286		39,286		39,286			42
43	Other (specify):* State Income Tax			101	101		101	(101)				43
44	TOTAL Special Cost Centers			39,387	39,387	1,153	40,540	(101)	40,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	291,292	58,533	239,175	589,000		589,000	(3,879)	585,121			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: 10/01/06

Ending: 09/30/07

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	BHF 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)	(200)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(660)	20		19
20	Contributions	(218)	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	(101)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,700)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,879)		\$	30

BHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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))	\$ (3,879)		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		\$ 1,153	25	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	TOTAL (C): (sum of lines 38-46)			\$ 1,153		47

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House

ID# 0037341

Report Period Beginning: 10/01/06

Ending: 09/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Depreciation - Central Office	\$ 345	30	1
2	Depreciation	(2,745)	30	2
3	Medical Director - 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	(2,700)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/06

Ending:

09/30/07

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	(878)	0	0	0	0	0	0	0	0	0	0	(878)	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	(200)	0	0	0	0	0	0	0	0	0	0	(200)	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	(1,078)	0	0	0	0	0	0	0	0	0	0	(1,078)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,378)	0	0	0	0	0	0	0	0	0	0	(1,378)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/06

Ending:

09/30/07

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	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400) 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	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400) 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):*	(101)	0	0	0	0	0	0	0	0	0	0	(101) 43
44	TOTAL Special Cost Centers	(101)	0	0	0	0	0	0	0	0	0	0	(101) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(3,879)	0	0	0	0	0	0	0	0	0	0	(3,879) 45

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: 10/01/06 Ending: 09/30/07

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	\$ 28,753	17.1	1
2	Daniel P. Caulkins	Vice President	Administration	50.00	Attached	10	25.00	Wages	28,753	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	\$ 57,506		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: 10/01/06 Ending: 09/30/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Patterson House** # **0037341** Report Period Beginning: **10/01/06** Ending: **09/30/07**

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				
	A. Directly Facility Related											
	Long-Term											
1	Regions Bank & Trust		X	Mortgage	\$3,600.00	10/27/03	\$ 200,399	\$ 75,708	09/28/08	5.0000	\$ 10,404	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank & Trust		X	Working Capital		12/01/03					10,649	6
7												7
8												8
9	TOTAL Facility Related				\$3,600.00		\$ 200,399	\$ 75,708			\$ 21,053	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	\$ 75,708			\$ 21,053	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

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2006 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.)		\$ 8,406	2	
3.	Under or (over) accrual (line 2 minus line 1).		\$ 3,496	3	
4.	Real Estate Tax accrual used for 2007 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.		\$ 8,406	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	7,846	8	
		2003	7,890	9	
		2004	8,276	10	
		2005	8,473	11	
		2006	8,406	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2006 \$		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: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 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 Costs

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of total cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 08-08-01-311-002	NE 1/4 & E 1/2 NW 1/4 Blk 7	\$ 8,406.34	\$ 8,406.34
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>8,406.34</u>	\$ <u>8,406.34</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 directly 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 home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

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

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	15,000	1990	\$ 16,205	1
2					2
3	TOTALS	15,000		\$ 16,205	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/01/06

Ending:

09/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1991	1991	\$ 233,435	\$ 5,836	40	\$ 5,836		\$ 92,889	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	47	10	47		440	13
14	Electrical system & alarm system improvements		4/1/1998	3,445		5			3,445	14
15	Fire protection system improvement		4/1/1998	698		5			698	15
16	Carpet replacement		8/23/2000	2,810		5			2,810	16
17	Roof		8/6/2007	11,410	380	5	380		380	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

XI. OWNERSHIP COSTS (continued)

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

	1	2	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)		\$ 277,917	\$ 6,263		\$ 6,263	\$	\$ 126,315		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 101,767	\$ 8,953	\$ 6,553	\$ (2,400)		\$ 83,180	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 101,767	\$ 8,953	\$ 6,553	\$ (2,400)		\$ 83,180	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)	\$ 395,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,816	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,400)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 209,495	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? YES NO
If NO, see instructions.

		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

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> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </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)

* 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.

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>12,673</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>12,673</u>	21

SEE ACCOUNTANTS' COMPILATION REPORT

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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	

- (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 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of 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

Page 17

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/01/06

Ending:

09/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 10,526	\$ 46,736	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	186,001	732,725	3
4	Supply Inventory (priced at Cost)	1,405	4,541	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	200	800	7
8	Accounts Receivable (owners or related parties)	58,433	233,271	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 256,565	\$ 1,018,073	10
B. Long-Term Assets				
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	15,157	177,525	15
16	Equipment, at Historical Cost	114,741	359,135	16
17	Accumulated Depreciation (book methods)	(210,230)	(465,917)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,232	10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,232)	(698,841)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>		746,682	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 194,546	\$ 406,952	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 451,111	\$ 1,425,025	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 55,499	\$ 145,755	26
27	Officer's Accounts Payable	1,150	4,600	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	153,250	613,000	29
30	Accrued Salaries Payable	9,665	38,660	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,101	39,202	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,201	25,540	32
33	Accrued Interest Payable		2,445	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Intercompany Account</u>	(520,366)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (281,500)	\$ 869,202	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,850	11,400	39
40	Mortgage Payable	75,708	360,792	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)	\$ 78,558	\$ 372,192	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (202,942)	\$ 1,241,394	46
47	TOTAL EQUITY(page 18, line 24)	\$ 654,053	\$ 183,631	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 451,111	\$ 1,425,025	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 576,706	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 576,706	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	122,889	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	(45,542)	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)	\$ 77,347	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)	\$ 654,053	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Patterson House

0037341

Report Period Beginning: 10/01/06

Ending:

Page 19

09/30/07

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	\$ 657,510	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 657,510	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	23,136	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)	\$ 23,136	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,174	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,174	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	30,069	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,069	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 711,889	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	131,155	31
32	Health Care	178,714	32
33	General Administration	180,446	33
B. Capital Expense			
34	Ownership	59,298	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	39,286	36
D. Other Expenses (specify):			
37	State Income Tax	101	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 589,000	40
41	Income before Income Taxes (line 30 minus line 40)**	122,889	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 122,889	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: 10/01/06

Ending: 09/30/07

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	11,694	11,694	99,047	8.47
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,780	2,780	25,618	9.22
10	Activity Assistants				10
11	Social Service Workers	2,200	2,200	30,489	13.86
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,077	2,077	21,683	10.44
15	Cook Helpers/Assistants	1,022	1,022	8,564	8.38
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	2,080	2,080	18,512	8.90
19	Laundry	1,167	1,167	9,783	8.38
20	Administrator	500	500	13,623	27.25
21	Assistant Administrator				21
22	Other Administrative	1,000	1,040	57,506	55.29
23	Office Manager				23
24	Clerical	500	520	6,467	12.44
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)	25,020	25,080	\$ 291,292 *	\$ 11.61

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	33	\$ 1,561	1.3
36	Medical Director	39	3,900	9.3
37	Medical Records Consultant			
38	Nurse Consultant	109	3,268	10.3
39	Pharmacist Consultant			
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant	2	66	10a.3
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	15	675	10.3
44	Activity Consultant	75	3,394	11.3
45	Social Service Consultant	26	915	12.3
46	Other(specify) Psychologist	46	2,286	10.3
47	Psychiatrist Consultant	4	217	10.3
48				
49	TOTAL (lines 35 - 48)	349	\$ 16,282	

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

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

** See instructions.

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	\$ 6,467	Workers' Compensation Insurance	\$ 9,543	IDPH License Fee	\$ 100		
Richard L. Grader	Administrative	50	28,753	Unemployment Compensation Insurance	3,297	Advertising: Employee Recruitment	43		
Daniel P. Caulkins	Administrative	50	28,753	FICA Taxes	21,497	Health Care Worker Background Check (Indicate # of checks performed _____)			
Lori Dillman	Administrator	0	13,623	Employee Health Insurance	18,165	Patient Background Checks			
				Employee Meals	3,650	Dues, Subs, Sundry	979		
				Illinois Municipal Retirement Fund (IMRF)*					
				Long-Term Care Insurance	1,244				
				Employee Physicals	1,214				
				Sundry	501				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,596	TOTAL (agree to Schedule V, line 22, col.8)		\$ 59,111	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,122
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) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$
C. Professional Services									
Vendor/Payee	Type		Amount						
May, Cocagne & King, P.C.	CPA		\$ 7,702						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,702	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	
1	Painting	01/04	\$ 3,500	5	\$ 467	\$ 700	\$ 700	\$ 700	\$ 700	\$	\$	\$	\$	\$
2	Painting	02/04	3,990	5	466	798	798	798	798					
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 7,490		\$ 933	\$ 1,498	\$ 1,498	\$ 1,498	\$ 1,498	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House# 0037341Report Period Beginning: 10/01/06Ending: 09/30/07**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 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. \$ 39,286
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 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 \$5,000, 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.

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

**Allocation of Central Office Costs
 Year Ended September 30, 2007**

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	30,806	7,702	7,702	7,702	7,702	19
Donations	873	218	218	218	218	20
Postage	2,757	689	689	689	689	21
Telephone	15,042	3,761	3,761	3,761	3,761	21
Utilities - Central Office	1,585	396	396	396	396	5
Group Insurance	72,661	18,165	18,165	18,165	18,165	22
Workers Comp Insurance	38,173	9,543	9,543	9,543	9,543	22
General Insurance	47,459	11,865	11,865	11,865	11,865	26
Business Meals	454	114	114	114	114	20
Depreciation	11,602	2,901	2,901	2,901	2,901	30
Interest expense	25,207	6,302	6,302	6,302	6,302	32
Lease Expense - Central Office	7,800	1,950	1,950	1,950	1,950	34
Rent - Vehicles	20,737	5,184	5,184	5,184	5,184	35
State Income Tax Expense	404	101	101	101	101	43
	<u>275,560.00</u>	<u>68,890.00</u>	<u>68,890.00</u>	<u>68,890.00</u>	<u>68,890.00</u>	

PATTERSON HOUSE

PAGE 3, LINE 25

September 30, 2007

Fuel and repairs for the facility vehicles	7,345
Reimbursement of employee, care-related local travel	<u>6,549</u>
	<u>13,894</u>
Reimbursement of employee, care-related travel	<u>(1,153)</u>
Page 3, Line 25	<u>12,741</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	624	7,489	
Administration	2005 Lexus	216	2,590	
	2006 Lexus	216	1,944	9 months
	2007 Mercedes	217	650	3 months
	TOTAL	1,272	12,673	

PATTERSON HOUSE

VEHICLE LEASES--CENTRAL OFFICE

September 30, 2007

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. Traded for 2007 Mercedes July 2007.

2007 Mercedes-used for facility business-Leased July, 2007.

The lease expense is as follows:

	2005 Lexus	2006 Lexus	2007 Mercedes
Monthly Payment	863	865	865
# of Months	12	9	3
	10,361	7,781	2,595
	x 25%	x 25%	x 25%
Facility allocation	2,590	1,945	649

CARLINVILLE ESTATES
EMERALD ESTATES
MARIGOLD ESTATES
PATTERSON HOUSE

RENT

9/30/2007

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, 2007

	<u>TOTAL COMP</u>	<u>CARLINVILLE ESTATES</u>	<u>EMERALD ESTATES</u>	<u>MARIGOLD ESTATES</u>	<u>PATTERSON HOUSE</u>
Richard L. Grader	115,016	28,754	28,754	28,754	28,754
Daniel P. Caulkins	<u>115,016</u>	<u>28,754</u>	<u>28,754</u>	<u>28,754</u>	<u>28,754</u>
	<u>230,032</u>	<u>57,508</u>	<u>57,508</u>	<u>57,508</u>	<u>57,508</u>

PATTERSON HOUSE

OWNER'S COMPENSATION

September 30, 2007

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, 2007

Page 19 Section E

Earning credits	11,121	
Reimburse residents travel	1,153	
Vehicle Lease	9,130	***
Miscellaneous	8,665	
	<u>30,069</u>	

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