



Facility Name & ID Number Emerald Estates

# 0039354 Report Period Beginning: 10/1/08 Ending: 9/30/09

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 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	5,308			5,308	13
14	TOTALS	5,308			5,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.89%

D. How many bed-hold days during this year were paid by the Department? 16 (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 12/1/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/1/93 NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 9/30/09

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/08 Ending: 9/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	33,937	4,111	1,411	39,459		39,459		39,459		1
2	Food Purchase		38,235		38,235		38,235		38,235		2
3	Housekeeping	18,142	5,282		23,424		23,424		23,424		3
4	Laundry		1,517		1,517		1,517		1,517		4
5	Heat and Other Utilities			22,116	22,116		22,116		22,116		5
6	Maintenance		3,079	12,028	15,107		15,107		15,107		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	52,079	52,224	35,555	139,858		139,858		139,858		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,100	1,100		1,100		1,100		9
10	Nursing and Medical Records	120,819	1,990	3,278	126,087		126,087		126,087		10
10a	Therapy			1,302	1,302		1,302		1,302		10a
11	Activities	26,350	1,995		28,345		28,345		28,345		11
12	Social Services	30,759		2,414	33,173		33,173		33,173		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Workshop</b>			193,253	193,253		193,253	(193,253)			15
16	<b>TOTAL Health Care and Programs</b>	177,928	3,985	201,347	383,260		383,260	(193,253)	190,007		16
	<b>C. General Administration</b>										
17	Administrative	92,370			92,370		92,370		92,370		17
18	Directors Fees										18
19	Professional Services			7,725	7,725		7,725		7,725		19
20	Dues, Fees, Subscriptions & Promotions			2,492	2,492		2,492	(345)	2,147		20
21	Clerical & General Office Expenses		6,038	6,275	12,313		12,313		12,313		21
22	Employee Benefits & Payroll Taxes			44,105	44,105		44,105	(35)	44,070		22
23	Inservice Training & Education			265	265		265		265		23
24	Travel and Seminar			678	678		678	(475)	203		24
25	Other Admin. Staff Transportation			12,493	12,493	(1,816)	10,677		10,677		25
26	Insurance-Prop.Liab.Malpractice			13,082	13,082		13,082		13,082		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	92,370	6,038	87,115	185,523	(1,816)	183,707	(855)	182,852		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	322,377	62,247	324,017	708,641	(1,816)	706,825	(194,108)	512,717		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 &amp; ID Number

Emerald Estates

#0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,234	7,234		7,234	8,428	15,662			30
31	Amortization of Pre-Op. & Org.			2,765	2,765		2,765	(2,765)				31
32	Interest			9,702	9,702		9,702	13,254	22,956			32
33	Real Estate Taxes			11,915	11,915		11,915		11,915			33
34	Rent-Facility & Grounds			37,146	37,146		37,146	(36,371)	775			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			68,762	68,762		68,762	(17,454)	51,308			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					1,816	1,816		1,816			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,366	32,366		32,366		32,366			42
43	Other (specify):* <b>IL Replacement Tax</b>			367	367		367	(367)				43
44	<b>TOTAL Special Cost Centers</b>			32,733	32,733	1,816	34,549	(367)	34,182			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	322,377	62,247	425,512	810,136		810,136	(211,929)	598,207			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

**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	(193,253)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(35)	22		19
20	Contributions	(206)	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	(139)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(367)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,240)	24,31		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (197,240)		\$	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)	(14,689)	30,32,34	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (14,689)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (211,929)		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		\$ 1,816	25
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					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 1,816	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Emerald Estates

ID# 0039354

Report Period Beginning: 10/1/08

Ending: 9/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Amortization - Goodwill	\$ (2,765)	31	1
2	Travel & Seminar - Entertainment	(35)	24	2
3	Travel & Seminar - Out of State	(440)	24	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	<b>Total</b>	(3,240)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

## 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	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(193,253)	0	0	0	0	0	0	0	0	0	0	(193,253)	15
16	<b>TOTAL Health Care and Programs</b>	(193,253)	0	0	0	0	0	0	0	0	0	0	(193,253)	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	(345)	0	0	0	0	0	0	0	0	0	0	(345)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(35)	0	0	0	0	0	0	0	0	0	0	(35)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(475)	0	0	0	0	0	0	0	0	0	0	(475)	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>	(855)	0	0	0	0	0	0	0	0	0	0	(855)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(194,108)	0	0	0	0	0	0	0	0	0	0	(194,108)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Estates# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	8,428	0	0	0	0	0	0	0	0	0	8,428	30
31	Amortization of Pre-Op. & Org.	(2,765)	0	0	0	0	0	0	0	0	0	0	(2,765)	31
32	Interest	0	13,254	0	0	0	0	0	0	0	0	0	13,254	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,371)	0	0	0	0	0	0	0	0	0	(36,371)	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>(2,765)</b>	<b>(14,689)</b>	<b>0</b>	<b>(17,454)</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):*	(367)	0	0	0	0	0	0	0	0	0	0	(367)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(367)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(367)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(197,240)</b>	<b>(14,689)</b>	<b>0</b>	<b>(211,929)</b>	<b>45</b>								

**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 L. Grader	50	Carlinville Estates	Carlinville	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Emerald Estates	Canton	R&D LLP	Decatur	Landlord
		Marigold Estates	Pekin			
		Patterson House	Sullivan			

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	30 Depreciation	\$	Two-Can, Inc.	100.00%	\$ 6,970	\$ 6,970	1
2	V	32 Interest		Two-Can, Inc.	100.00%	3,968	3,968	2
3	V	34 Rent	29,496	Two-Can, Inc.	100.00%		(29,496)	3
4	V	30 Depreciation		R&D LLP	100.00%	1,458	1,458	4
5	V	32 Interest		R&D LLP	100.00%	9,286	9,286	5
6	V	34 Rent	6,875	R&D LLP	100.00%		(6,875)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 36,371			\$ 21,682	\$ * (14,689)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Emerald Estates

#

0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

## 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 Attached	10	25.00	Wages	\$ 36,505	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	36,505	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	\$ 73,010		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 Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending: 9/30/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Central Office - Patterson House, Inc.  
 Street Address 636 West Imboden  
 City / State / Zip Code Decatur, IL 62521  
 Phone Number ( 217) 422-6510  
 Fax Number ( 217) 422-6819

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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				\$	\$		\$	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

Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Regions Bank & Trust		X	Mortgage		07/01/08	\$ 525,000	\$ 496,744	07/01/13	Variable	\$ 26,356	1							
2	Related Parties	X		Interest Income						2.8000	(5,673)	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Regions Bank & Trust		X	Working Capital		12/01/03		96,000		2.7500	2,273	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 525,000	\$ 592,744			\$ 22,956	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>						\$ 525,000	\$ 592,744			\$ 22,956	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**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and																	
1. Real Estate Tax accrual used on 2008 report.		\$	<b>8,604</b>	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.)		\$	<b>11,725</b>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,121</b>	3															
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>8,794</b>	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.		\$	<b>11,915</b>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2004	<b>9,680</b>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2008 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2008 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2008 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2005	<b>9,483</b>	9																
	2006	<b>9,195</b>	10																
	2007	<b>8,972</b>	11																
	2008	<b>9,181</b>	12																
<b>Line 2, R/E taxes paid: Emerald Estates bill \$9,181 + \$2,544 (1/4) Central Office bill = \$11,725</b>																			
<b>Line 4, R/E tax accrual: 9/12 Emerald Estates bill \$6,886 + \$1,908 (1/4) 9/12 Central Office bill = \$8,794</b>																			

**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



Facility Name & ID Number Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,356 B. General Construction Type: Exterior Brick-Vinyl Frame Wood Number of Stories One

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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>29,642</u>	<u>1993</u>	<u>\$ 18,934</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>29,642</b>		<b>\$ 18,934</b>	<b>3</b>

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1993	1989	\$ 273,944	\$ 6,970	39	\$ 6,970	\$	\$ 106,968
5									
6									
7									
8	Central Office	2005		134,436	1,458	39	1,458		2,543
	Improvement Type**								
9	Remodeling, flooring		1996	10,099	505	20	505		6,606
10	Remodeling, flooring		1996	6,110	157	39	157		2,050
11	Driveway		1999	11,000	733	15	733		7,517
12	Waterheater		2001	2,000		7			2,000
13	Carpet		2004	3,007	501	5	501		3,007
14	New sinks and faucets		2004	1,190	170	7	170		765
15	Bathroom remodeling - new plumbing, flooring, walls		2006	12,862	330	39	330		934
16	Bathroom remodeling - new plumbing, flooring, walls		2007	6,708	172	39	172		401
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Central Office - track lights and receptacles		2009	324	7	20	7		7
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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)	\$	\$		\$	\$	\$	70
		461,680	11,003		11,003		132,798	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

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	\$ 59,201	\$ 3,495	\$ 3,495	\$		\$ 53,157	71
72	Current Year Purchases	15,829	1,164	1,164			1,164	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 75,030	\$ 4,659	\$ 4,659	\$		\$ 54,321	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)	\$ 555,644	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,662	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,662	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 187,119	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: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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.

**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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<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

Facility Name & ID Number Emerald Estates# 0039354Report Period Beginning: 10/1/08Ending: 9/30/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	202,145	978,324	3
4	Supply Inventory (priced at )	3,324	11,904	4
5	Short-Term Investments			5
6	Prepaid Insurance	75	299	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	431,275	1,725,101	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 636,819	\$ 2,715,628	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		273,574	14
15	Leasehold Improvements, at Historical Cost	53,299	187,845	15
16	Equipment, at Historical Cost	75,030	359,804	16
17	Accumulated Depreciation (book methods)	(77,608)	(508,239)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe loan fees, net)	2,767	11,069	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 53,488	\$ 344,603	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 690,307	\$ 3,060,231	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 4,783	\$ 26,346	26
27	Officer's Accounts Payable	1,662	6,648	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	96,000	384,000	29
30	Accrued Salaries Payable	15,086	56,189	30
31	Accrued Taxes Payable (excluding real estate taxes)	110	442	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,794	35,736	32
33	Accrued Interest Payable	502	2,008	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Cash drawn in excess	11,684	46,584	36
37	Intercompany	611,699		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 750,320	\$ 557,953	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	496,744	1,986,978	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 (sum of lines 39 thru 44)</b>	\$ 496,744	\$ 1,986,978	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,247,064	\$ 2,544,931	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (556,757)	\$ 515,300	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 690,307	\$ 3,060,231	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(496,981)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Reverse 9/30/08 accrued taxes payable</b>	<b>(395)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(497,376)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(21,881)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(37,500)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(59,381)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(556,757)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Emerald Estates

# 0039354

Report Period Beginning: 10/1/08

Ending:

9/30/09

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	\$ 570,387	1
2	Discounts and Allowances for all Levels	(4,623)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 565,764	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>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,796	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 13,796	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Attached Schedule</a>	208,695	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 208,695	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 788,255	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	139,858	31
32	Health Care	383,260	32
33	General Administration	183,707	33
<b>B. Capital Expense</b>			
34	Ownership	68,762	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,816	35
36	Provider Participation Fee	32,366	36
<b>D. Other Expenses (specify):</b>			
37	<a href="#">IL replacement tax</a>	367	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 810,136	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(21,881)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (21,881)	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.

\*\*\* 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 Emerald Estates

# 0039354

Report Period Beginning:

10/1/08

Ending:

9/30/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,777	17,368	9.30	9
10	Activity Assistants	952	8,982	9.43	10
11	Social Service Workers	2,053	30,759	14.70	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,418	17,024	10.98	14
15	Cook Helpers/Assistants	1,757	16,913	9.63	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,784	18,142	9.34	18
19	Laundry				19
20	Administrator	484	14,247	27.40	20
21	Assistant Administrator				21
22	Other Administrative	1,000	73,010	70.20	22
23	Office Manager				23
24	Clerical	466	5,113	10.35	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)	12,286	120,819	9.46	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	23,977	322,377 *	12.90	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	30	\$ 1,411	1, 3	35
36	Medical Director	100/mo	1,100	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	51	1,519	10, 3	38
39	Pharmacist Consultant	100/visit	100	10, 3	39
40	Physical Therapy Consultant	5	396	10a, 3	40
41	Occupational Therapy Consultant		14	10a, 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	76	10a, 3	43
44	Activity Consultant				44
45	Social Service Consultant	44	2,414	12, 3	45
46	Other(specify)				46
47	Psychologist	14	816	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)	145	\$ 7,846		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Emerald Estates

# 0039354

Report Period Beginning: 10/1/08

Ending: 9/30/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 yrs
- (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. \$ 32,336  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,816  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Page 3, Part V

Line 25 Other Admin. Staff Transportation

Fuel	2,553
Mileage	4,017
Vehicle Maintenance	<u>5,923</u>
	12,493
Less special cost center - medically necessary transportation	<u>(1,816)</u>
	<u><u>10,677</u></u>

Patterson House, Inc.  
Carlinville Estates  
Emerald Estates (# 0039354)  
Marigold Estates  
Patterson House

10/1/08 - 9/30/09

Page 6, Part VII, B

The facility buildings and land are owned by a related corporation, Two-Can, Inc. Two-Can, Inc. has the same shareholders as Patterson House, Inc.

Two-Can, Inc. has the following basis in the building and land:

	<u>Land</u>	<u>Building</u>
Carlinville Estates	18,747	269,911
Emerald Estates	18,934	273,944
Marigold Estates	18,622	273,263

Interest accrued by Two-Can, Inc. on its mortgage was as follows:

Regions Bank	15,872
--------------	--------

The interest is allocated as follows:

Carlinville Estates	3,968
Emerald Estates	3,968
Marigold Estates	3,968
Patterson House	3,968

Patterson House, Inc.  
Carlinville Estates  
Emerald Estates (# 0039354)  
Marigold Estates  
Patterson House

10/1/08 - 9/30/09

Page 6, Part VII, B

The Central Office building and land are owned by a related corporation, R&D LLP.  
R&D LLP has the same shareholders as Patterson House, Inc.

R&D LLP has the following basis in the building:

Carlinville Estates	134,436
Emerald Estates	134,436
Marigold Estates	134,436
Patterson House	134,436

Interest accrued by R&D LLP on its mortgage was as follows:

Regions Bank	37,144
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The interest is allocated as follows:

Carlinville Estates	9,286
Emerald Estates	9,286
Marigold Estates	9,286
Patterson House	9,286

Patterson House, Inc.  
 Carlinville Estates  
 Emerald Estates (# 0039354)  
 Marigold Estates  
 Patterson House

10/1/08 - 9/30/09

Page 7, Part VII, C

Owners' Compensation  
 10/1/08 - 9/30/09

	<u>Total Compensation</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>
Richard L. Grader	146,020	36,505	36,505	36,505	36,505
Daniel P. Caulkins	<u>146,020</u>	<u>36,505</u>	<u>36,505</u>	<u>36,505</u>	<u>36,505</u>
	<u><u>292,040</u></u>	<u><u>73,010</u></u>	<u><u>73,010</u></u>	<u><u>73,010</u></u>	<u><u>73,010</u></u>

Patterson House, Inc.  
Carlinville Estates  
Emerald Estates (# 0039354)  
Marigold Estates  
Patterson House

10/1/08 - 9/30/09

Owners' Compensation  
10/1/08 - 9/30/09

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

Richard L. Grader:

- Purchasing
- Approving vendors
- Reviewing accounts receivable
- Following up on billing discrepancies
- Managing cash flow
- Negotiating with the bank
- Bookkeeping
- All financial management functions

Daniel P. Caulkins:

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

Both owners:

- Reviewing vendor invoices
- Paying invoices
- Dealing with local day program agencies
- Attending employee meetings
- Recruiting employees
- Dealing with employee complaints

The above duties are not all encompassing.

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2009

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	Carlinville 25%	Emerald 25%	Marigold 25%	Patterson House 25%	Line Ref
Dietary Supplies	108	27	27	27	27	1
Food Costs	912	228	228	228	228	1
Housekeeping Supplies	1,140	285	285	285	285	3
Utilities	7,938	1,985	1,985	1,984	1,984	5
Maintenance	5,822	1,455	1,455	1,456	1,456	6
Administrative Salaries	369,479	92,370	92,370	92,370	92,369	17
Professional Services	25,900	6,475	6,475	6,475	6,475	19
Dues, Fees and Subscription	5,727	1,432	1,432	1,431	1,432	20
Contributions	825	206	206	207	206	20
Office Supplies	4,638	1,160	1,159	1,160	1,159	21
Other Office Expense	8,028	2,007	2,007	2,007	2,007	21
Postage	3,710	928	928	927	927	21
Telephone	11,428	2,857	2,857	2,857	2,857	21
Payroll Taxes	22,651	5,663	5,662	5,663	5,663	22
Group Health Insurance	44,603	11,150	11,151	11,151	11,151	22
Workers Comp Insurance	17,296	4,324	4,324	4,324	4,324	22
Business Meals	2,301	575	576	575	575	22
Entertainment	139	35	34	35	35	22
Other Employee Benefits	3,755	939	938	939	939	22
Inservice Training & Educatic	1,061	265	266	265	265	23
Travel and Seminars	2,713	678	679	678	678	24
Other Admin/Staff Transporta	14,516	3,629	3,629	3,629	3,629	25
Insurance	52,329	13,083	13,082	13,082	13,082	26
Depreciation	5,487	1,372	1,372	1,371	1,372	30
Interest Expense	61,501	15,375	15,375	15,375	15,376	32
Real Estate Taxes	10,310	2,577	2,577	2,578	2,578	33
Lease - Central Office	28,100	7,025	7,025	7,025	7,025	34
IL Replacement Tax	1,468	367	367	367	367	43
	<u>713,885</u>	<u>178,472</u>	<u>178,471</u>	<u>178,471</u>	<u>178,471</u>	

Patterson House, Inc.  
Carlinville Estates  
Emerald Estates (# 0039354)  
Marigold Estates  
Patterson House

10/1/08 - 9/30/09

Page 9, Part IX

Mortgage

The mortgage dated 7/1/08 at Regions Bank is allocated as follows:

Regions Bank - balance @ 9/30/09	<u>1,986,978</u>
Carlinville Estates	496,744
Emerald Estates	496,744
Marigold Estates	496,745
Patterson House	496,745

Pg 19, Part XVII

Line 21 Other Medical Services

HAB Aid training reimbursement	<u><u>13,796</u></u>
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Line 28 Other Revenue

Earning credits	13,626
Reimburse residents' travel	1,816
Workshop	<u>193,253</u>
	<u><u>208,695</u></u>

Facility fiscal year end is 9/30/09, tax year end is 12/31/09. Taxable income will not agree.

Page 23, Part XX, Line 12

Individual employees may work in several different departments. An individual employee's wages are allocated to the specific departments based on the hours worked in those departments.