



Facility Name & ID Number Patterson House

# 0037341 Report Period Beginning: 10/1/13 Ending: 9/30/14

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 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,089			5,089	13
14	TOTALS	5,089			5,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.14%

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

85 (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 11/15/1991

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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 9/30/14

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

**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	30,132	2,392	1,463	33,987		33,987	33,987			1
2	Food Purchase		36,030		36,030		36,030	36,030			2
3	Housekeeping	35,678	2,223		37,901		37,901	37,901			3
4	Laundry		2,152		2,152		2,152	2,152			4
5	Heat and Other Utilities			19,277	19,277		19,277	19,277			5
6	Maintenance		1,881	13,631	15,512		15,512	15,512			6
7	Other (specify):* <b>Garbage</b>			2,897	2,897		2,897	2,897			7
8	<b>TOTAL General Services</b>	65,810	44,678	37,268	147,756		147,756	147,756			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,850	3,850		3,850	3,850			9
10	Nursing and Medical Records	104,890	4,037	7,615	116,542		116,542	116,542			10
10a	Therapy			1,582	1,582		1,582	1,582			10a
11	Activities	31,341	2,316		33,657		33,657	33,657			11
12	Social Services	28,413		1,531	29,944		29,944	29,944			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Workshop</b>			175,689	175,689		175,689	(175,689)			15
16	<b>TOTAL Health Care and Programs</b>	164,644	6,353	190,267	361,264		361,264	(175,689)	185,575		16
	<b>C. General Administration</b>										
17	Administrative	74,978			74,978		74,978	74,978			17
18	Directors Fees										18
19	Professional Services			11,990	11,990		11,990	11,990			19
20	Dues, Fees, Subscriptions & Promotions			1,970	1,970		1,970	(456)	1,514		20
21	Clerical & General Office Expenses		5,198	7,141	12,339		12,339	12,339			21
22	Employee Benefits & Payroll Taxes			62,691	62,691		62,691	(162)	62,529		22
23	Inservice Training & Education			377	377		377	377			23
24	Travel and Seminar			149	149		149	149			24
25	Other Admin. Staff Transportation			11,211	11,211	(808)	10,403	10,403			25
26	Insurance-Prop.Liab.Malpractice			12,029	12,029		12,029	12,029			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	74,978	5,198	107,558	187,734	(808)	186,926	(618)	186,308		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	305,432	56,229	335,093	696,754	(808)	695,946	(176,307)	519,639		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Patterson House

#0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			9,674	9,674		9,674	3,319	12,993			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,482	9,482		9,482	8,159	17,641			32
33	Real Estate Taxes			9,615	9,615		9,615		9,615			33
34	Rent-Facility & Grounds			8,700	8,700		8,700	(8,700)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>IL Repl tax</b>			2,844	2,844		2,844	(2,844)				36
37	<b>TOTAL Ownership</b>			40,315	40,315		40,315	(66)	40,249			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					808	808		808			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,067	40,067		40,067		40,067			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			40,067	40,067	808	40,875		40,875			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	305,432	56,229	415,475	777,136		777,136	(176,373)	600,763			45

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

Facility Name & ID Number Patterson House

# 0037341

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**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	(175,689)	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	(223)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(519)	36		18
19	Entertainment	(162)	22		19
20	Contributions	(193)	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	(40)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,325)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (179,151)		\$	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)	2,778	30,32,34	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2,778		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (176,373)		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		\$ 808	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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 808		47

Patterson House

ID# 0037341

Report Period Beginning: 10/1/13

Ending: 9/30/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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>	<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>0</b>	<b>0</b>	<b>8</b>
	<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):*	(175,689)	0	0	0	0	0	0	0	0	0	0	(175,689)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(175,689)</b>	<b>0</b>	<b>(175,689)</b>	<b>16</b>									
	<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	(456)	0	0	0	0	0	0	0	0	0	0	(456)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(162)	0	0	0	0	0	0	0	0	0	0	(162)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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>	<b>(618)</b>	<b>0</b>	<b>(618)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(176,307)</b>	<b>0</b>	<b>(176,307)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

## 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	3,319	0	0	0	0	0	0	0	0	0	3,319	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	8,159	0	0	0	0	0	0	0	0	0	8,159	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(8,700)	0	0	0	0	0	0	0	0	0	(8,700)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,844)	0	0	0	0	0	0	0	0	0	0	(2,844)	36
37	<b>TOTAL Ownership</b>	<b>(2,844)</b>	<b>2,778</b>	<b>0</b>	<b>(66)</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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(179,151)</b>	<b>2,778</b>	<b>0</b>	<b>(176,373)</b>	<b>45</b>								

Facility Name & ID Number

Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard L. Grader	50	Carlville Estates	Carlville	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	32 Interest	\$	Two-Can, Inc	100.00%	\$ 2,248	\$ 2,248	1
2	V	30 Depreciation		R&D LLP	100.00%	3,319	3,319	2
3	V	32 Interest		R&D LLP	100.00%	5,911	5,911	3
4	V	34 Rent	8,700	R&D LLP	100.00%		(8,700)	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		\$ 8,700			\$ 11,478	\$ * 2,778	14

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

Facility Name & ID Number

Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/13 Ending: 9/30/14

## 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	\$ 23,678	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	23,678	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	\$ 47,356		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending: 9/30/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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 - PG29				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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

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

1	Name of Lender	2		3	4	5	6		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	Town & Country Bank		X	Mortgage - refinanced		7/1/13	\$ 486,000	\$ 480,467	7/1/18	3.5000	\$ 17,659						
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500	8,046	11/14/15	3.9500	465						
3	Related Parties	X		Interest Income						0.2200	(585)						
4																	
5																	
<b>Working Capital</b>																	
6	Town & Country Bank		X	Working Capital		2/9/10					190						
7	Town & Country Bank		X	Interest Income							(22)						
8	State of Illinois		X	Interest Income							(66)						
9	<b>TOTAL Facility Related</b>						\$ 508,500	\$ 488,513			\$ 17,641						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 508,500	\$ 488,513			\$ 17,641						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2013 report.		\$	<b>6,339</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>9,420</b>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,081</b>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>6,534</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>9,615</b>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>8,203</u>	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 2013 \$</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 2013 \$	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 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>8,283</u>	9																
	2011	<u>6,066</u>	10																
	2012	<u>6,203</u>	11																
	2013	<u>6,445</u>	12																
<b>Line 2, R/E taxes paid: Patterson House bill \$6,445 + \$2,975 Central Office bill = \$9,420</b>																			
<b>Line 4, R/E tax accrual: 9/12 Patterson House bill \$4,844 + \$1,690 Central Office bill = \$6,534</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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Patterson House COUNTY Moultrie  
 FACILITY IDPH LICENSE NUMBER 0037341  
 CONTACT PERSON REGARDING THIS REPORT David W. White, C.P.A.  
 TELEPHONE (217) 423-6000 FAX #: (217) 423-6100

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-08-01-311-002</u>	<u>NE1/4&amp;E1/2 NW1/4 BLK 7 Kellars</u>	\$ <u>6,445.26</u>	\$ <u>6,445.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>6,445.26</u></u>	\$ <u><u>6,445.26</u></u>

**B. Real Estate Tax Cost Allocations**

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 and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Patterson House

# 0037341 Report Period Beginning:

10/1/13 Ending:

9/30/14

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (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).

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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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>15,000</u>	<u>1991</u>	<u>\$ 20,550</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>15,000</b>		<b>\$ 20,550</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1991	1991	\$ 230,924	\$ 5,773	39	\$ 5,773	\$	\$ 133,786
5									
6									
7									
8	Central Office	2005		119,594	3,319	39	3,319		21,821
	Improvement Type**								
9	Driveways		1991	16,799		40			16,799
10	Landscaping		1991	4,593		10			4,593
11	New floor/tile		1998	2,759		10			2,759
12	New carpet		2000	2,810		10			2,810
13	New roof		2007	11,410	570	20	570		4,089
14	Bathroom/kitchen remodeling		2007	3,223	215	15	215		1,450
15	(2) exit doors		2008	3,866	258	15	258		1,503
16	(3) outswing entry doors		2009	3,025	201	15	201		992
17	(2) Furnaces		2013	7,991	205	39	205		273
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Central Office - tracklights and receptacles		2009	324	19	20	19		102
31	Central Office - new roof		2012	4,700	140	39	140		256
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

Facility Name & ID Number **Patterson House**

# **0037341**

Report Period Beginning:

10/1/13

Ending:

9/30/14

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 412,018	\$ 10,700		\$ 10,700	\$	\$ 191,233	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 121,227	\$ 1,725	\$ 1,725	\$	7	\$ 119,737	71
72	Current Year Purchases	4,406	568	568		7	567	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 125,633	\$ 2,293	\$ 2,293	\$		\$ 120,304	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 558,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,993	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,993	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)	\$ 311,537	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.

Facility Name & ID Number

Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/13 Ending: 9/30/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

<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.

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

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

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning: 10/1/13

Ending:

9/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/14

(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	\$ 31,192	\$ 107,764	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	38,385	235,593	3
4	Supply Inventory (priced at )	2,460	10,315	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,536	8,744	7
8	Accounts Receivable (owners or related parties)	431,815	1,489,017	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 506,388</b>	<b>\$ 1,851,433</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,550	20,550	13
14	Buildings, at Historical Cost	284,590	284,590	14
15	Leasehold Improvements, at Historical Cost	7,834	249,565	15
16	Equipment, at Historical Cost	125,633	551,748	16
17	Accumulated Depreciation (book methods)	(286,767)	(729,289)	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 (spec <u>Loan Fees, net</u> )	3,403	11,733	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 155,243</b>	<b>\$ 388,897</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 661,631</b>	<b>\$ 2,240,330</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 6,616	\$ 48,792	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,508	37,812	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,591	15,831	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,534	33,524	32
33	Accrued Interest Payable	1,028	3,544	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Intercompany</u>	(863,149)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ (835,872)</b>	<b>\$ 139,503</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	13,710	47,275	39
40	Mortgage Payable	480,467	1,656,783	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>	<b>\$ 494,177</b>	<b>\$ 1,704,058</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ (341,695)</b>	<b>\$ 1,843,561</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,003,326</b>	<b>\$ 396,769</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 661,631</b>	<b>\$ 2,240,330</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,078,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,078,323	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	45,603	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	(120,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (74,997)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>		23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,003,326	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 621,112	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 621,112	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	22,777	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 22,777	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	See attached schedule - PG31	178,850	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 178,850	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 822,739	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	147,756	31
32	Health Care	361,264	32
33	General Administration	186,926	33
<b>B. Capital Expense</b>			
34	Ownership	40,315	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	808	35
36	Provider Participation Fee	40,067	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 777,136	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	45,603	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 45,603	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 621,112	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 621,112	49

\* 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.

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

Facility Name & ID Number Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending:

9/30/14

**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	1,755	1,885	20,981	11.13	9
10	Activity Assistants	968	1,098	10,361	9.44	10
11	Social Service Workers	2,010	2,010	28,413	14.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,810	1,935	22,132	11.44	14
15	Cook Helpers/Assistants	704	829	7,999	9.65	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,646	3,804	35,678	9.38	18
19	Laundry					19
20	Administrator	535	603	18,453	30.60	20
21	Assistant Administrator					21
22	Other Administrative	1,113	1,206	47,452	39.35	22
23	Office Manager					23
24	Clerical	538	603	9,073	15.05	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)	10,538	10,711	104,890	9.79	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,617	24,684	\$ 305,432 *	\$ 12.37	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	\$ 1,463	1,3	35
36	Medical Director	\$350/month	3,850	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	174	6,102	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	631	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	31	1,531	12	45
46	Other(specify)				46
47	Psychologist Consultant	16	951	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	265	\$ 14,528		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



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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Patterson House

# 0037341

Report Period Beginning:

10/1/13

Ending: 9/30/14

## 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? 7 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. \$ 40,067  
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. \$ 808  
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**Page 3, Part V**

Line 23 - Inservice Training & Education

Consultants	<u>377</u>
	<u><u>377</u></u>

Line 25 - Other Admin. Staff Transportation

Fuel	5,340
Mileage	4,728
Vehicle Maintenance	<u>1,143</u>
Subtotal	11,211
Less special cost center - medically necessary transportation	(808)
	<u><u>10,402</u></u>

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

10/1/13 - 9/30/14

(#0037341)

**Page6, Part VII, Table B**

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

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

	<u>Buildings</u>	<u>Land</u>
Carlinville Estates	274,054	18,747
Emerald Estates	273,944	18,934
Marigold Estates	273,263	18,622

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

Town & Country Bank	7,751
---------------------	-------

The interest is allocated as follows:

Carlinville Estates	2,093
Emerald Estates	1,317
Marigold Estates	2,093
Patterson House	<u>2,248</u>
	<u><u>7,751</u></u>

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

10/1/13 - 9/30/14

(#0037341)

**Page 6, Part VII, B**

The Central Office building and land are owned by a related limited liability partnership, 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	119,594
Emerald Estates	119,594
Marigold Estates	119,594
Patterson House	119,594

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

Town & Country Bank	<u>20,384</u>
---------------------	---------------

The interest is allocated as follows:

Carlinville Estates	5,504
Emerald Estates	3,465
Marigold Estates	5,504
Patterson House	<u>5,911</u>
	<u>20,384</u>



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

(#0037341)

10/1/13 - 9/30/14

Page 7, Part VII, C

Owners' Compensation  
10/1/13 - 9/30/14

	<u>Total Compensation</u>	<u>Carlenville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>
Richard L. Grader	81,649	22,045	13,880	22,046	23,678
Daniel P. Caulkins	81,649	22,045	13,880	22,045	23,678
	<u>163,298</u>	<u>44,090</u>	<u>27,761</u>	<u>44,091</u>	<u>47,356</u>

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

10/1/13 - 9/30/14

(#0037341)

Owners' Compensation  
10/1/13 - 9/30/14

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.

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

(#0037341)

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2014

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

All costs of the central office and common costs are allocated as follows:

Carlinville - 27%, Emerald - 17%, Marigold - 27%, Patterson - 29%

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

	<u>Total Expense</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>	<u>Line Ref</u>
Food costs	966	261	164	261	280	1
Housekeeping Supplies	349	94	60	94	101	3
Utilities	12,547	3,388	2,133	3,388	3,638	5
Maintenance	5,585	1,508	949	1,508	1,620	6
Nursing Consultant fees	143	38	24	38	42	10
Administrative Salaries	214,522	57,921	36,469	57,921	62,211	17
Professional Services	39,172	10,576	6,659	10,576	11,361	19
Dues, Fees and Subscriptions	3,133	846	533	846	908	20
Contributions	500	135	85	135	145	20
Office Supplies	2,036	550	346	550	590	21
Other Office Expense	5,301	1,431	901	1,431	1,538	21
Postage	4,992	1,348	849	1,348	1,447	21
Telephone	11,115	3,001	1,889	3,001	3,224	21
Payroll Taxes	16,448	4,441	2,796	4,441	4,770	22
Group Health Insurance	102,193	27,592	17,373	27,592	29,636	22
Long-Term Care Insurance	19,474	5,258	3,311	5,258	5,647	22
Workers Comp Insurance	31,661	8,549	5,382	8,549	9,181	22
Business Meals	1,630	440	277	440	473	22
Entertainment	386	104	66	104	112	22
Other Employee Benefits	12,479	3,369	2,121	3,369	3,620	22
Inservice Training & Education	1,298	350	221	350	377	23
Travel and seminars	515	139	88	139	149	24
Other Admin/Staff Transportation	30,859	8,332	5,246	8,332	8,949	25

Insurance	41,479	11,199	7,051	11,199	12,030	26
Depreciation	3,707	1,001	630	1,001	1,075	30
Interest Expense	32,760	8,845	5,569	8,845	9,501	32
Real Estate Taxes	10,302	2,782	1,751	2,782	2,987	33
Lease - Central Office	52,122	14,073	8,861	14,073	15,115	34
IL replacement tax	8,017	2,165	1,363	2,165	2,325	36
	<u>665,691</u>	<u>179,736</u>	<u>113,167</u>	<u>179,736</u>	<u>193,052</u>	

Patterson House, Inc. 10/1/13 - 9/30/14  
Carlinville Estates  
Emerald Estates  
Marigold Estates  
Patterson House (#0037341)

Page 9, Part IX

Mortgage

The mortgage dated 7/1/13 at Town & Country Bank is allocated as follows:

Town & Country Bank - balance @ 9/30/14	<u>1,656,782</u>
Carlinville Estates	447,331
Emerald Estates	281,653
Marigold Estates	447,331
Patterson House	480,467

Patterson House (#0037341)

10/1/13 - 9/31/14

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>22,777</u>
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Line 28, Other Revenue

Earning Credits	2,353
Residents' travel reimbursement	808
Workshop	<u>175,689</u>
	<u>178,850</u>

\*\*Facility fiscal year end is 9/30/14, tax year end is 12/31/14.

Taxable income will not agree.

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.