

Facility Name & ID Number Patterson House

0037341 Report Period Beginning: 10/1/15 Ending: 9/30/16

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	5,856	6
7	16	TOTALS	16	5,856	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	5,047			5,047	13
14	TOTALS	5,047			5,047	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.19%

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

189 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 9/30/16

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/15 Ending: 9/30/16

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
	A. General Services										
1	Dietary	29,913	2,468	1,488	33,869		33,869		33,869		1
2	Food Purchase		35,858		35,858		35,858		35,858		2
3	Housekeeping	37,460	2,972		40,432		40,432		40,432		3
4	Laundry		813		813		813		813		4
5	Heat and Other Utilities			24,456	24,456		24,456		24,456		5
6	Maintenance		2,284	27,794	30,078		30,078		30,078		6
7	Other (specify):*										7
8	TOTAL General Services	67,373	44,395	53,738	165,506		165,506		165,506		8
	B. Health Care and Programs										
9	Medical Director			3,850	3,850		3,850		3,850		9
10	Nursing and Medical Records	117,288	5,692	8,562	131,542		131,542		131,542		10
10a	Therapy			2,353	2,353		2,353		2,353		10a
11	Activities	32,153	1,739		33,892		33,892		33,892		11
12	Social Services	35,713		690	36,403		36,403		36,403		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Workshop			178,590	178,590		178,590	(178,590)			15
16	TOTAL Health Care and Programs	185,154	7,431	194,045	386,630		386,630	(178,590)	208,040		16
	C. General Administration										
17	Administrative	72,933			72,933		72,933		72,933		17
18	Directors Fees										18
19	Professional Services			16,526	16,526		16,526	(5,330)	11,196		19
20	Dues, Fees, Subscriptions & Promotions			1,329	1,329		1,329	(227)	1,102		20
21	Clerical & General Office Expenses		5,814	9,292	15,106		15,106		15,106		21
22	Employee Benefits & Payroll Taxes			57,085	57,085		57,085	(134)	56,951		22
23	Inservice Training & Education			756	756		756		756		23
24	Travel and Seminar			36	36		36		36		24
25	Other Admin. Staff Transportation			10,712	10,712	(966)	9,746		9,746		25
26	Insurance-Prop.Liab.Malpractice			6,884	6,884		6,884		6,884		26
27	Other (specify):*										27
28	TOTAL General Administration	72,933	5,814	102,620	181,367	(966)	180,401	(5,691)	174,710		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	325,460	57,640	350,403	733,503	(966)	732,537	(184,281)	548,256		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 & ID Number

Patterson House

#0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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			10,143	10,143		10,143	2,193	12,336		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			9,256	9,256		9,256	6,231	15,487		32
33	Real Estate Taxes			9,683	9,683		9,683		9,683		33
34	Rent-Facility & Grounds			7,800	7,800		7,800	(7,800)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*			1,020	1,020		1,020	(1,020)			36
37	TOTAL Ownership			37,902	37,902		37,902	(396)	37,506		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					966	966		966		38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			39,649	39,649		39,649	(494)	39,155		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			39,649	39,649	966	40,615	(494)	40,121		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	325,460	57,640	427,954	811,054		811,054	(185,171)	625,883		45

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

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	(178,590)	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	(173)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(494)	42		18
19	Entertainment	(134)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,330)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(54)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,020)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,795)		\$	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)	624	30,32,34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 624		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (185,171)		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		\$ 966	25
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 966	47

BHF USE ONLY							
48		49		50		51	

Patterson House

ID# 0037341

Report Period Beginning: 10/1/15

Ending: 9/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
B. Health Care and Programs														
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):*	(178,590)	0	0	0	0	0	0	0	0	0	0	(178,590)	15
16	TOTAL Health Care and Programs	(178,590)	0	0	0	0	0	0	0	0	0	0	(178,590)	16
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,330)	0	0	0	0	0	0	0	0	0	0	(5,330)	19
20	Fees, Subscriptions & Promotions	(227)	0	0	0	0	0	0	0	0	0	0	(227)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(134)	0	0	0	0	0	0	0	0	0	0	(134)	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	TOTAL General Administration	(5,691)	0	0	0	0	0	0	0	0	0	0	(5,691)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(184,281)	0	0	0	0	0	0	0	0	0	0	(184,281)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	2,193	0	0	0	0	0	0	0	0	0	2,193	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,231	0	0	0	0	0	0	0	0	0	6,231	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(7,800)	0	0	0	0	0	0	0	0	0	(7,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,020)	0	0	0	0	0	0	0	0	0	0	(1,020)	36
37	TOTAL Ownership	(1,020)	624	0	(396)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	(494)	0	0	0	0	0	0	0	0	0	0	(494)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(494)	0	0	0	0	0	0	0	0	0	0	(494)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(185,795)	624	0	(185,171)	45								

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	100	Carlville Estates	Carlville	Two-Can, Inc.	Decatur	Landlord
		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	32 Interest	\$	Two-Can, Inc	100.00%	\$ 1,728	\$ 1,728	1
2	V	30 Depreciation		R&D LLP	100.00%	2,193	2,193	2
3	V	32 Interest		R&D LLP	100.00%	4,503	4,503	3
4	V	34 Rent	7,800	R&D LLP	100.00%		(7,800)	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		\$ 7,800			\$ 8,424	\$ * 624	14

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

Facility Name & ID Number

Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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: 10/1/15 Ending: 9/30/16

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	100.00	See attached	10	20.00	Wages	\$ 23,565	17,1	1
2	Daniel P. Caulkins	Vice President	Administration		See attached	10	20.00	Wages	23,565	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	\$ 47,130		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:

10/1/15

Ending: 9/30/16

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

Facility Name & ID Number

Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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		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			
A. Directly Facility Related																		
Long-Term																		
1	Town & Country Bank		X	Mortgage - refinanced		7/1/13	\$ 486,000	\$	9/16/16	3.5000	\$ 14,272	1						
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500		11/14/15	3.9500	19	2						
3	Related Parties	X		Interest income						0.2200	(673)	3						
4	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	722,800	722,800	9/16/19	3.6500		4						
5												5						
Working Capital																		
6	Town & Country Bank		X	Working Capital		2/9/10	182,000			4.5000	2,238	6						
7	Town & Country Bank		X	Interest Income							(9)	7						
8	Hickory Point Bank		X	Working Capital		9/16/16	182,000	182,000		3.5000		8						
9	TOTAL Facility Related						\$ 1,595,300	\$ 904,800			\$ 15,847	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,595,300	\$ 904,800			\$ 15,847	15						

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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	5,947	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.)		\$	9,415	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,468	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	6,215	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	9,683	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	6,066	8
	2012	6,203	9
	2013	6,445	10
	2014	6,475	11
	2015	6,675	12

FOR BHF USE ONLY

Line 2, R/E taxes paid: Patterson House bill \$6,675 + \$2,740 Central Office bill = \$9,415	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
Line 4, R/E tax accrual: 9/12 Patterson House bill \$5,007 + Central Office bill \$1,208 = \$6,215	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-08-01-311-002</u>	<u>NE1/4&1/2NW1/4BLK 7 Kellars</u>	\$ <u>6,675.62</u>	\$ <u>6,675.62</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>6,675.62</u></u>	\$ <u><u>6,675.62</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

10/1/15

Ending:

9/30/16

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? [X] (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? [X] (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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: Facility, 15,000, 1991, \$ 20,550, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 15,000, (blank), \$ 20,550, 3.

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	\$	\$ 145,332
5									
6									
7									
8	Central Office	2005		79,729		39	2,193	2,193	18,918
	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	571	20	571		5,230
14	Bathroom/kitchen remodeling		2007	3,223	215	15	215		1,880
15	(2) exit doors		2008	3,866	257	15	257		2,019
16	(3) outswing entry doors		2009	3,025	202	15	202		1,395
17	(2) Furnaces		2013	7,991	205	39	205		683
18	Bathroom remodel - tub/shower surround, faucet, 2 assist bars		2016	6,598		39			
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Central office - track lights & receptacles		2009	216	17	20	17		125
32	New roof		2012	3,133	125	39	125		480
33	Permanent landscaping		2015	1,204	188	10	188		203
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:

10/1/15

Ending:

9/30/16

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	TOTAL (lines 4 thru 69)	\$	\$ 378,280		\$ 7,553	\$ 9,746	\$ 2,193	\$ 203,226	70

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

Facility Name & ID Number Patterson House

0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16

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	\$ 124,242	\$ 2,208	\$ 2,208	\$	Varies	\$ 120,080	71
72	Current Year Purchases	15,176	382	382		7	382	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 139,418	\$ 2,590	\$ 2,590	\$		\$ 120,462	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)	\$ 538,248	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,143	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,336	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,193	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 323,688	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.

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

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Patterson House**

0037341

Report Period Beginning: **10/1/15**

Ending:

9/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 107,146	\$ 412,367	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,178	341,869	3
4	Supply Inventory (priced at cost)	1,829	6,690	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,842	22,469	7
8	Accounts Receivable (owners or related parties)	722,008	2,776,956	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 933,003	\$ 3,560,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,550	20,550	13
14	Buildings, at Historical Cost	291,187	291,187	14
15	Leasehold Improvements, at Historical Cost	7,363	276,938	15
16	Equipment, at Historical Cost	141,819	615,094	16
17	Accumulated Depreciation (book methods)	(307,171)	(845,678)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 153,748	\$ 358,091	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,086,751	\$ 3,918,441	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 19,874	\$ 128,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,328	53,250	30
31	Accrued Taxes Payable (excluding real estate taxes)	654	2,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,215	38,147	32
33	Accrued Interest Payable	1,025	3,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany</u>	(835,369)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (796,273)	\$ 226,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,586	39
40	Mortgage Payable	904,800	3,480,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 904,800	\$ 3,491,586	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 108,527	\$ 3,718,134	46
47	TOTAL EQUITY(page 18, line 24)	\$ 978,224	\$ 200,307	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,086,751	\$ 3,918,441	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,004,844	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,004,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	57,282	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	(83,902)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (26,620)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 978,224	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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 665,374	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 665,374	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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	23,380	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,380	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	179,582	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 179,582	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 868,336	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	165,506	31
32	Health Care	386,630	32
33	General Administration	180,401	33
B. Capital Expense			
34	Ownership	37,902	34
C. Ancillary Expense			
35	Special Cost Centers	966	35
36	Provider Participation Fee	39,649	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 811,054	40
41	Income before Income Taxes (line 30 minus line 40)**	57,282	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,282	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 665,374	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 665,374	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:

10/1/15

Ending:

9/30/16

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	1,602	1,664	18,925	11.37
10	Activity Assistants	1,322	1,322	13,228	10.01
11	Social Service Workers	2,488	2,640	35,713	13.53
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,970	2,103	25,010	11.89
15	Cook Helpers/Assistants	493	493	4,903	9.95
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	3,787	3,986	37,460	9.40
19	Laundry				19
20	Administrator	440	541	16,731	30.93
21	Assistant Administrator				21
22	Other Administrative	998	1,082	47,130	43.56
23	Office Manager				23
24	Clerical	495	541	9,072	16.77
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)	10,554	11,019	117,288	10.64
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	24,149	25,391	\$ 325,460 *	\$ 12.82

* 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	\$ 1,488	1,3
36	Medical Director	monthly fee	3,850	9,3
37	Medical Records Consultant			37
38	Nurse Consultant	182	7,288	10,3
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	12	562	10a,3
44	Activity Consultant			44
45	Social Service Consultant	9	690	12
46	Other(specify)			46
47	Psychologist Consultant	15	1,209	10a,3
48	Psychiatrist Consultant	7	582	10a,3
49	TOTAL (lines 35 - 48)	255	\$ 15,669	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

Facility Name & ID Number Patterson House# 0037341

Report Period Beginning:

10/1/15

Ending:

9/30/16**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. \$ 39,649
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. \$ 966
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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Patterson House, (#0037341)

10/1/15 - 9/31/16

Page 4, Part V

Line 36, Other

IL replacement tax

1,020

Patterson House, Inc.		
Carlenville Estates		10/1/15 - 9/30/16
Emerald Estates		
Marigold Estates		
Patterson House	(#0037341)	

Page 6, 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>
Carlenville 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	5,849
---------------------	-------

The interest is allocated as follows:

Carlenville Estates	1,595
Emerald Estates	931
Marigold Estates	1,595
Patterson House	<u>1,728</u>
	<u><u>5,849</u></u>

Patterson House, Inc.	10/1/15 - 9/30/16
Carlinville Estates	
Emerald Estates	
Marigold Estates	
Patterson House	(#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	79,729
Emerald Estates	79,729
Marigold Estates	79,729
Patterson House	79,729

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

Town & Country Bank	<u>15,240</u>
---------------------	---------------

The interest is allocated as follows:

Carlinville Estates	4,156
Emerald Estates	2,425
Marigold Estates	4,157
Patterson House	<u>4,503</u>
	<u><u>15,240</u></u>

Patterson House, Inc.
 Carlinville Estates
 Emerald Estates
 Marigold Estates
 Patterson House (#0037341)

10/1/15 - 9/30/16

Page 7, Part VII, C

Owners' Compensation
 10/1/15 - 9/30/16

	<u>Total Compensation</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>	<u>Elin House (CILA)</u>	<u>Greykin House (CILA)</u>
Richard L. Grader	91,459	21,752	12,688	21,753	23,565	5,020	6,591
Daniel P. Caulkins**	<u>91,459</u>	<u>21,752</u>	<u>12,689</u>	<u>21,752</u>	<u>23,565</u>	<u>5,020</u>	<u>6,591</u>
	<u>182,917</u>	<u>43,504</u>	<u>25,377</u>	<u>43,505</u>	<u>47,131</u>	<u>10,041</u>	<u>13,183</u>

** Daniel P. Caulkins was 50% owner through 9/16/16. This compensation was paid while he was 50% owner.
 Richard Grader became 100% owner on 9/16/16.

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

10/1/15 - 9/30/16

(#0037341)

Owners' Compensation
10/1/15 - 9/30/16

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.
 Carlenville Estates
 Emerald Estates
 Marigold Estates
 Patterson House

(#0037341)

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2016

The group consists of four DD homes (16 beds each) and two CILA homes (10 beds)

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

Carlenville - 24%, Emerald - 14%, Marigold - 24%, Patterson - 26%, CILA's - 12%

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

	Total Expense	Carlenville Estates	Emerald Estates	Marigold Estates	Patterson House	CILA Homes	Line Ref
Food costs	934	224	131	224	243	112	1
Housekeeping Supplies	135	32	19	32	35	16	3
Utilities	11,876	2,850	1,663	2,850	3,088	1,425	5
Maintenance	8,564	2,055	1,199	2,055	2,227	1,028	6
Nondepreciable equipment (consumable items)		0	0	0	0	0	7
Nursing Consultant fees	235	56	33	56	61	28	10
Administrative Salaries	217,598	52,223	30,464	52,223	56,575	26,112	17
Professional Services	59,359	15,338	9,942	15,338	16,525	2,216	19
Dues, Fees and Subscriptions	2,209	530	309	530	574	265	20
Contributions	0	0	0	0	0	0	20
Office Supplies	3,618	868	506	868	941	434	21
Other Office Expense	15,263	3,663	2,137	3,663	3,968	1,832	21
Postage	4,534	1,088	635	1,088	1,179	544	21
Telephone	11,504	2,761	1,611	2,761	2,991	1,380	21
Payroll Taxes	18,901	4,536	2,646	4,536	4,914	2,268	22
Group Health Insurance	117,220	28,133	16,411	28,133	30,477	14,066	22
Long-Term Care Insurance	6,811	1,635	954	1,635	1,771	817	22
Workers Comp Insurance	21,147	5,075	2,961	5,075	5,498	2,538	22
Business Meals	341	82	48	82	89	41	22
Entertainment	516	124	72	124	134	62	22
Other Employee Benefits	8,688	2,085	1,216	2,085	2,259	1,043	22
Inservice Training & Education	1,370	329	192	329	356	164	23
Travel and seminars	125	30	18	30	33	15	24
Other Admin/Staff Transportation	30,181	7,244	4,225	7,244	7,847	3,622	25
Insurance	26,477	6,354	3,707	6,354	6,884	3,177	26
Depreciation	4,148	995	581	995	1,078	498	30
Interest Expense	35,666	8,560	4,993	8,560	9,273	4,280	32
Real Estate Taxes	10,987	2,637	1,538	2,637	2,857	1,318	33
Lease - Central Office	34,000	8,160	4,760	8,160	8,840	4,080	34
IL replacement tax	3,923	942	549	942	1,020	471	36
	<u>656,332</u>	<u>158,612</u>	<u>93,518</u>	<u>158,612</u>	<u>171,738</u>	<u>73,853</u>	

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

10/1/15 - 9/30/16

(#0037341)

Page 9, Part IX

Mortgage

The mortgage dated 9/16/16 at Hickory Point Bank is allocated as follows:

Balance @ 9/30/16 2,780,000

Carlinville Estates	667,200
Emerald Estates	389,200
Marigold Estates	667,200
Patterson House	722,800

Patterson House, (#0037341)

10/1/15 - 9/31/16

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>23,380</u>
--------------------------------	---------------

Line 28, Other Revenue

Social security reimbursement	(1,406)
Earning Credits	1,070
Residents' travel reimbursement	966
Gain on asset disposal	335
Miscellaneous income	27
Workshop	<u>178,590</u>
	179,582

**Facility fiscal year end is 9/30/16, tax year end is 12/31/16.
Taxable income will not agree.

Page 22, 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.