FOR BHF USE

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IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0039354

Facility Name: Emerald Estates

Address: 1577 East Myrtle, P O Box 232 (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 647-6604 **Fax #** (309) 647-0440

HFS ID Number:

Date of Initial License for Current Owners: 10/26/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas W. Hill, C.P.A., C.V.A. **Telephone Number:** (217) 425-4800
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Daniel P. Caulkins
(Title) Vice-President

Paid Preparer

(Signed) (Date)
(Print Name and Title) Thomas W. Hill, C.P.A., C.V.A.
(Firm Name & Address) Hill & White L.L.C.
132 South Water Street, Suite 500, Decatur, IL 62523
(Telephone) (217) 425-4800 Fax # (217) 425-8866

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,789			5,789	13
14	TOTALS	5,789			5,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.13%

D. How many bed-hold days during this year were paid by the Department?
24 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/93

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/10 Fiscal Year: 9/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	24,862	3,612	1,400	29,874		29,874		29,874			1
2	Food Purchase		39,473		39,473		39,473		39,473			2
3	Housekeeping	21,813	3,404		25,217		25,217		25,217			3
4	Laundry		2,155		2,155		2,155		2,155			4
5	Heat and Other Utilities			20,651	20,651		20,651		20,651			5
6	Maintenance		2,221	13,092	15,313		15,313		15,313			6
7	Other (specify):* Garbage			2,009	2,009		2,009		2,009			7
8	TOTAL General Services	46,675	50,865	37,152	134,692		134,692		134,692			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	117,700	2,362	3,253	123,315		123,315		123,315			10
10a	Therapy			985	985		985		985			10a
11	Activities	26,407	2,302		28,709		28,709		28,709			11
12	Social Services	31,677		1,611	33,288		33,288		33,288			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			263,546	263,546		263,546	(263,546)				15
16	TOTAL Health Care and Programs	175,784	4,664	270,395	450,843		450,843	(263,546)	187,297			16
	C. General Administration											
17	Administrative	64,844			64,844		64,844		64,844			17
18	Directors Fees											18
19	Professional Services			8,063	8,063		8,063		8,063			19
20	Dues, Fees, Subscriptions & Promotions			2,150	2,150		2,150	(270)	1,880			20
21	Clerical & General Office Expenses		5,450	6,053	11,503		11,503		11,503			21
22	Employee Benefits & Payroll Taxes			44,087	44,087		44,087	(149)	43,938			22
23	Inservice Training & Education			30	30		30		30			23
24	Travel and Seminar			406	406		406	(375)	31			24
25	Other Admin. Staff Transportation			8,292	8,292	(2,064)	6,228		6,228			25
26	Insurance-Prop.Liab.Malpractice			11,330	11,330		11,330		11,330			26
27	Other (specify):*											27
28	TOTAL General Administration	64,844	5,450	80,411	150,705	(2,064)	148,641	(794)	147,847			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	287,303	60,979	387,958	736,240	(2,064)	734,176	(264,340)	469,836			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			7,637	7,637		7,637	11,091	18,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,111	13,111		13,111	12,994	26,105			32
33	Real Estate Taxes			12,714	12,714		12,714		12,714			33
34	Rent-Facility & Grounds			36,996	36,996		36,996	(36,996)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			70,458	70,458		70,458	(12,911)	57,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,064	2,064		2,064			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,498	32,498		32,498		32,498			42
43	Other (specify):* IL Replacement Tax			1,981	1,981		1,981	(1,981)				43
44	TOTAL Special Cost Centers			34,479	34,479	2,064	36,543	(1,981)	34,562			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	287,303	60,979	492,895	841,177		841,177	(279,232)	561,945			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(263,546)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(149)	22		19
20	Contributions	(37)	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	(233)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,981)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(375)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (266,321)		$	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 Amount	2 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)	(12,911)	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (12,911)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (279,232)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 2,064	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	**TOTAL (C): (sum of lines 38-46)**			$ 2,064		47

SEE ACCOUNTANTS' COMPILATION REPORT

Emerald Estates

ID# 0039354

Report Period Beginning: 10/1/09

Ending: 9/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Travel and Seminar - Out of State	$ (375)	24	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**	(375)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	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):*	(263,546)	0	0	0	0	0	0	0	0	0	0	(263,546)	15
16	**TOTAL Health Care and Programs**	(263,546)	0	0	0	0	0	0	0	0	0	0	(263,546)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(270)	0	0	0	0	0	0	0	0	0	0	(270)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(149)	0	0	0	0	0	0	0	0	0	0	(149)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(375)	0	0	0	0	0	0	0	0	0	0	(375)	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**	(794)	0	0	0	0	0	0	0	0	0	0	(794)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(264,340)	0	0	0	0	0	0	0	0	0	0	(264,340)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	11,091	0	0	0	0	0	0	0	0	0	11,091	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	12,994	0	0	0	0	0	0	0	0	0	12,994	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,996)	0	0	0	0	0	0	0	0	0	(36,996)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(12,911)	0	0	0	0	0	0	0	0	0	(12,911)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,981)	0	0	0	0	0	0	0	0	0	0	(1,981)	43
44	**TOTAL Special Cost Centers**	(1,981)	0	0	0	0	0	0	0	0	0	0	(1,981)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(266,321)	(12,911)	0	0	0	0	0	0	0	0	0	(279,232)	45

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard L. Grader	50	Carlinville Estates	Carlinville	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Emerald Estates	Canton	R&D LLP	Decatur	Landlord
		Marigold Estates	Pekin			
		Patterson House	Sullivan			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Two-Can, Inc.	100.00%	$ 6,970	$ 6,970	1
2	V	32	Interest		Two-Can, Inc.	100.00%	3,698	3,698	2
3	V	34	Rent	29,496	Two-Can, Inc.	100.00%		(29,496)	3
4	V	30	Depreciation		R&D LLP	100.00%	4,121	4,121	4
5	V	32	Interest		R&D LLP	100.00%	9,296	9,296	5
6	V	34	Rent	7,500	R&D LLP	100.00%		(7,500)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,996			$ 24,085	$ * (12,911)	14

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

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Richard L. Grader	President	Administration	50.00	See Attached	10	25.00	Wages	$ 22,387	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	22,387	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	$ 44,774		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 Emerald Estates # 0039354 Report Period Beginning: 10/1/09 Ending: 9/30/10

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 [X] NO [ ]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Regions Bank & Trust		X	Mortgage		07/01/08	$ 525,000	$ 471,856	07/01/13	Variable	$ 24,588	1
2	Related Parties	X		Interest Income						0.8200	(2,472)	2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank & Trust		X	Working Capital		12/01/03				2.7500	1,077	6
7	Town & Country Bank		X	Working Capital		01/11/10				4.5000	2,912	7
8												8
9	TOTAL Facility Related						$ 525,000	$ 471,856			$ 26,105	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 525,000	$ 471,856			$ 26,105	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	8,794	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.)	$	12,290	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,496	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	9,218	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.	$	12,714	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	9,483	8
2006	9,195	9
2007	8,972	10
2008	9,181	11
2009	9,703	12

Line 2, R/E taxes paid: Emerald Estates bill $9,703 + $2,587 (1/4) Central Office bill = $12,290

Line 4, R/E taxes accrual: 9/12 Emerald Estates bill $7,278 + $1,940 (1/4) 9/12 Central Office bill = $9,218

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Estates COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0039354

CONTACT PERSON REGARDING THIS REPORT Thomas W. Hill, C.P.A., C.V.A.

TELEPHONE (217) 425-4800 FAX #: (217) 425-8866

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-102-007	Village Sq Sub Div Sec 5, Lot 7	$ 354.62	$ 354.62
2.	09-08-25-102-008	Village Sq Sub Div Sec 5, Lot 8	$ 354.62	$ 354.62
3.	09-08-25-102-009	Village Sq Sub Div Sec 5, Lot 9	$ 8,994.08	$ 8,994.08
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 9,703.32	$ 9,703.32

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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).

None

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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,642	1993	$ 18,934	1
2					2
3	TOTALS	29,642		$ 18,934	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1989	$ 273,944	$ 6,970	39	$ 6,970	$	$ 113,938	4
5											5
6											6
7											7
8	Central Office		2005		169,949	4,121	39	4,121		6,664	8
	Improvement Type**										
9	Remodeling, flooring			1996	10,099	505	20	505		7,111	9
10	Remodeling, flooring			1996	6,110	157	39	157		2,207	10
11	Driveway			1999	11,000	733	15	733		8,250	11
12	Waterheater			2001	2,000		7			2,000	12
13	Carpet			2004	3,007		5			3,007	13
14	New sinks and faucets			2004	1,190	170	7	170		935	14
15	Bathroom remodeling - new plumbing, flooring, walls			2006	12,862	330	39	330		1,264	15
16	Bathroom remodeling - new plumbing, flooring, walls			2007	6,708	172	39	172		573	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	Central Office - track lights and receptacles			2009	324	16	20	16		23	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 497,193	$ 13,174		$ 13,174	$	$ 145,972	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 75,030	$ 4,548	$ 4,548	$		$ 58,869	71
72	Current Year Purchases	20,012	1,006	1,006			1,006	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 95,042	$ 5,554	$ 5,554	$		$ 59,875	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 611,169	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,728	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)	$ 205,847	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 Emerald Estates # 0039354 Report Period Beginning: 10/1/09 Ending: 9/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	1	2	3	4	5	6	7	8	
	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 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	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 45,855	$ 183,572	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	98,152	424,475	3
4	Supply Inventory (priced at)	2,420	8,587	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,991	7,964	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	392,597	1,570,386	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 541,015	$ 2,194,984	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		276,599	14
15	Leasehold Improvements, at Historical Cost	53,299	187,845	15
16	Equipment, at Historical Cost	95,042	388,747	16
17	Accumulated Depreciation (book methods)	(85,245)	(543,542)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **loan fees, net**	2,029	8,118	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 65,125	$ 338,317	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 606,140	$ 2,533,301	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,811	$ 24,442	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,839	57,925	30
31	Accrued Taxes Payable (excluding real estate taxes)	376	1,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,218	33,143	32
33	Accrued Interest Payable	495	1,981	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Intercompany	737,444		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 766,183	$ 118,994	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	471,856	1,887,424	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)**	$ 471,856	$ 1,887,424	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,238,039	$ 2,006,418	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (631,899)	$ 526,883	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 606,140	$ 2,533,301	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (556,757)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (556,757)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,761	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	(117,903)	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)**	$ (75,142)	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)**	$ (631,899)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 609,303	1
2	Discounts and Allowances for all Levels	(5,394)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 603,909	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	6,661	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,661	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	273,368	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 273,368	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 883,938	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	134,692	31
32	Health Care	450,843	32
33	General Administration	148,641	33
	B. Capital Expense		
34	Ownership	70,458	34
	C. Ancillary Expense		
35	Special Cost Centers	2,064	35
36	Provider Participation Fee	32,498	36
	D. Other Expenses (specify):		
37	IL Replacement Tax	1,981	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 841,177	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,761	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,761	43

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

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

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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	1,863	1,891	17,833	9.43	9
10	Activity Assistants	901	901	8,574	9.52	10
11	Social Service Workers	2,099	2,111	31,677	15.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,505	1,626	15,938	9.80	14
15	Cook Helpers/Assistants	1,002	1,002	8,924	8.91	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,247	2,272	21,813	9.60	18
19	Laundry					19
20	Administrator	469	520	14,450	27.79	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	44,774	43.05	22
23	Office Manager					23
24	Clerical	460	512	5,620	10.98	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)	11,974	12,328	117,700	9.55	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,520	24,203	$ 287,303 *	$ 11.87	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	$ 1,400	1 , 3	35
36	Medical Director	100/mo	1,000	9 , 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	89	2,673	10 , 3	38
39	Pharmacist Consultant	100/visit			39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	1,611	12 , 3	45
46	Other(specify)				46
47	Psychologist Consultant	16	985	10a , 3	47
48					48
49	TOTAL (lines 35 - 48)	164	$ 7,669		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	50	$ 22,387
Daniel P. Caulkins	Administrative	50	22,387
Lora A. Dillman	Administrative		14,450
Jennifer Haseley	Office Assistant		5,620
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,844

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Hill & White L.L.C.	C.P.A.	$ 8,063
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,063

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,075
Unemployment Compensation Insurance	2,370
FICA Taxes	20,532
Employee Health Insurance	8,786
Employee Meals	928
Illinois Municipal Retirement Fund (IMRF)*	
Long-Term Care Insurance	2,639
Employee Awards	75
Employee Medical Expenses	1,389
Other Employee Expenses	2,144
TOTAL (agree to Schedule V, line 22, col.8)	$ 43,938

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	551
Health Care Worker Background Check	50
(Indicate # of checks performed 5)	
Patient Background Checks	
Dues and Subscriptions	886
Fees and Licenses	393
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	31
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 31

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. $ **32,498**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee 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. $ **2,064**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, Part V

Line 25 Other Admin. Staff Transportation

Fuel	2,732
Mileage	4,434
Vehicle Maintenance	1,126
	8,292
Less special cost center - medically necessary transportation	(2,064)
	6,228

Page 6, Part VII, B

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

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

	Buildings	Land
Carlinville Estates	269,911	18,747
Emerald Estates	273,944	18,934
Marigold Estates	273,263	18,622

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

Regions Bank	14,792

The interest is allocated as follows:

Carlinville Estates	3,698
Emerald Estates	3,698
Marigold Estates	3,698
Patterson House	3,698

Page 6, Part VII, B

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

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

Carlinville Estates	169,949
Emerald Estates	169,949
Marigold Estates	169,949
Patterson House	169,949

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

Regions Bank	37,184

The interest is allocated as follows:

Carlinville Estates	9,296
Emerald Estates	9,296
Marigold Estates	9,296
Patterson House	9,296

Patterson House, Inc. 10/1/09 - 9/30/10
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 7, Part VII, C

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

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House
Richard L. Grader	89,548	22,387	22,387	22,387	22,387
Daniel P. Caulkins	89,548	22,387	22,387	22,387	22,387
	179,096	44,774	44,774	44,774	44,774

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House, Inc. 10/1/09 - 9/30/10
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

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

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. 10/1/09 - 9/30/10
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2010

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

All costs of the central office and common costs are allocated 25% to each facility.

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

	Total Expense	Carlinville 25%	Emerald 25%	Marigold 25%	Patterson House 25%	Line Ref
Dietary Supplies	49	13	12	12	12	1
Food Costs	1,007	251	252	252	252	1
Housekeeping Supplies	635	159	158	159	159	3
Utilities	8,225	2,056	2,057	2,056	2,056	5
Maintenance	6,642	1,660	1,660	1,661	1,661	6
Administrative Salaries	259,377	64,845	64,844	64,844	64,844	17
Professional Services	27,250	6,812	6,812	6,813	6,813	19
Advertising - promotional	437	109	110	109	109	20
Dues, Fees and Subscriptions	3,210	802	802	803	803	20
Contributions	150	38	38	37	37	20
Office Supplies	6,440	1,610	1,610	1,610	1,610	21
Other Office Expense	5,600	1,400	1,400	1,400	1,400	21
Postage	4,796	1,199	1,199	1,199	1,199	21
Telephone	12,880	3,220	3,220	3,220	3,220	21
Payroll Taxes	16,150	4,037	4,037	4,038	4,038	22
Group Health Insurance	35,146	8,787	8,787	8,786	8,786	22
Long-Term Care Insurance	10,555	2,638	2,639	2,639	2,639	22
Workers Comp Insurance	20,298	5,075	5,074	5,074	5,075	22
Business Meals	2,556	639	639	639	639	22
Entertainment	596	149	149	149	149	22
Other Employee Benefits	1,903	476	476	476	475	22
Travel and Seminars	1,625	406	406	406	407	24
Other Admin/Staff Transportation	11,904	2,976	2,976	2,976	2,976	25
Insurance	62,224	15,556	15,556	15,556	15,556	26
Depreciation	6,537	1,634	1,634	1,635	1,634	30
Interest Expense	54,452	13,613	13,613	13,613	13,613	32
Real Estate Taxes	10,476	2,619	2,619	2,619	2,619	33
Lease - Central Office	30,000	7,500	7,500	7,500	7,500	34
IL Replacement Tax	7,922	1,981	1,981	1,980	1,980	36
	609,042	152,260	152,260	152,261	152,261	

Patterson House, Inc. 10/1/09 - 9/30/10
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 9, Part IX

Mortgage

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

Regions Bank - balance @ 9/30/10	1,887,424

Carlinville Estates	471,856
Emerald Estates	471,856
Marigold Estates	471,856
Patterson House	471,856

Page 19, Part XVII

Line 21 Other Medical Services

HAB Aid training reimbursement	6,661

Line 28 Other Revenue

Earning Credits	7,758
Reimburse residents' travel	2,064
Workshop	263,546
	273,368

Facility fiscal year end is 9/30/10, tax year end is 12/31/10. Taxable income will not agree.

Emerald Estates (# 0039354) 10/1/09 - 9/30/10

Page 23, Part XX, Line 12

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

SEE ACCOUNTANTS' COMPILATION REPORT