		FOR BHF USE					

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0037341

Facility Name: Patterson House

Address: 307 East Jefferson (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4357 **Fax #** (217) 782-2017

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: David W. White, C.P.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 10/1/10 to 9/30/11 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) David W. White, C.P.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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	5,606			5,606	13
14	TOTALS	5,606			5,606	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.99%

D. How many bed-hold days during this year were paid by the Department?
10 (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 11/15/91

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

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: 12/31/11 Fiscal Year: 9/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	33,016	1,143	1,200	35,359		35,359		35,359			1
2	Food Purchase		34,480		34,480		34,480		34,480			2
3	Housekeeping	37,759	3,479		41,238		41,238		41,238			3
4	Laundry		1,362		1,362		1,362		1,362			4
5	Heat and Other Utilities			19,324	19,324		19,324		19,324			5
6	Maintenance		1,654	11,797	13,451		13,451		13,451			6
7	Other (specify):* Garbage			2,081	2,081		2,081		2,081			7
8	**TOTAL General Services**	70,775	42,118	34,402	147,295		147,295		147,295			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	92,742	3,460	6,528	102,730		102,730		102,730			10
10a	Therapy			1,824	1,824		1,824		1,824			10a
11	Activities	28,821	2,905		31,726		31,726		31,726			11
12	Social Services	32,225		1,664	33,889		33,889		33,889			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			128,160	128,160		128,160	(128,160)				15
16	**TOTAL Health Care and Programs**	153,788	6,365	142,376	302,529		302,529	(128,160)	174,369			16
	C. General Administration											
17	Administrative	63,455			63,455		63,455		63,455			17
18	Directors Fees											18
19	Professional Services			9,012	9,012		9,012		9,012			19
20	Dues, Fees, Subscriptions & Promotions			3,027	3,027		3,027	(1,587)	1,440			20
21	Clerical & General Office Expenses		5,652	5,248	10,900		10,900		10,900			21
22	Employee Benefits & Payroll Taxes			46,860	46,860		46,860	(128)	46,732			22
23	Inservice Training & Education			472	472		472		472			23
24	Travel and Seminar			705	705		705	(450)	255			24
25	Other Admin. Staff Transportation			11,648	11,648	(3,398)	8,250		8,250			25
26	Insurance-Prop.Liab.Malpractice			9,279	9,279		9,279		9,279			26
27	Other (specify):*											27
28	**TOTAL General Administration**	63,455	5,652	86,251	155,358	(3,398)	151,960	(2,165)	149,795			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	288,018	54,135	263,029	605,182	(3,398)	601,784	(130,325)	471,459			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Patterson House #0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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			12,996	12,996		12,996	3,326	16,322			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			445	445		445	12,246	12,691			32
33	Real Estate Taxes			10,946	10,946		10,946		10,946			33
34	Rent-Facility & Grounds			7,500	7,500		7,500	(7,500)				34
35	Rent-Equipment & Vehicles			4,365	4,365		4,365		4,365			35
36	Other (specify):*											36
37	**TOTAL Ownership**			36,252	36,252		36,252	8,072	44,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,398	3,398		3,398			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,727	40,727		40,727		40,727			42
43	Other (specify):* **IL Replacement Tax**			5,283	5,283		5,283	(5,283)				43
44	**TOTAL Special Cost Centers**			46,010	46,010	3,398	49,408	(5,283)	44,125			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	288,018	54,135	345,291	687,444		687,444	(127,536)	559,908			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	(128,160)	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	(128)	22		19
20	Contributions	(1,538)	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	(49)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,283)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(450)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,608)		$	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)	8,072	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 8,072		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (127,536)		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		$ 3,398	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)**			$ 3,398		47

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House

ID# 0037341

Report Period Beginning: 10/1/10

Ending: 9/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Travel and Seminar - Out of State	$ (450)	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**	(450)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Patterson House **#** 0037341 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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):* **Workshop**	(128,160)	0	0	0	0	0	0	0	0	0	0	(128,160)	15
16	**TOTAL Health Care and Programs**	(128,160)	0	0	0	0	0	0	0	0	0	0	(128,160)	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	(1,587)	0	0	0	0	0	0	0	0	0	0	(1,587)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(128)	0	0	0	0	0	0	0	0	0	0	(128)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(450)	0	0	0	0	0	0	0	0	0	0	(450)	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**	(2,165)	0	0	0	0	0	0	0	0	0	0	(2,165)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(130,325)	0	0	0	0	0	0	0	0	0	0	(130,325)	29

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House # 0037341 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	3,326	0	0	0	0	0	0	0	0	0	3,326	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	12,246	0	0	0	0	0	0	0	0	0	12,246	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(7,500)	0	0	0	0	0	0	0	0	0	(7,500)	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	8,072	0	0	0	0	0	0	0	0	0	8,072	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):* **IL Replacement T**	(5,283)	0	0	0	0	0	0	0	0	0	0	(5,283)	43
44	**TOTAL Special Cost Centers**	(5,283)	0	0	0	0	0	0	0	0	0	0	(5,283)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,608)	8,072	0	0	0	0	0	0	0	0	0	(127,536)	45

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard L. Grader	50	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	32	Interest	$	Two-Can, Inc.	100.00%	$ 3,449	$ 3,449	1
2	V	30	Depreciation		R&D LLP	100.00%	3,326	3,326	2
3	V	32	Interest		R&D LLP	100.00%	8,797	8,797	3
4	V	34	Rent	7,500	R&D LLP	100.00%		(7,500)	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			$ 7,500			$ 15,572	$ * 8,072	14

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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: 10/1/10 Ending: 9/30/11

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	$ 21,733	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	21,733	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	$ 43,466		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: 10/1/10 Ending: 9/30/11

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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	$ 444,984	07/01/13	Variable	$ 23,232	1
2	Related Parties	X		Interest Income						0.5900	(1,116)	2
3												3
4												4
5												5
	Working Capital											
6	Town & Country Bank		X	Working Capital		02/09/10		70,500		4.5000	646	6
7	Town & Country Bank		X	Interest Income							(84)	7
8	IL Dept of Public Aid		X	Interest Income							(9,987)	8
9	TOTAL Facility Related						$ 525,000	$ 515,484			$ 12,691	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	$ 515,484			$ 12,691	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 Patterson House # 0037341 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 8,092	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.)		$ 10,879	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,787	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 8,159	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.		$ 10,946	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	8,406	8
	2007	8,100	9
	2008	8,084	10
	2009	8,203	11
	2010	8,283	12

Line 2, R/E taxes paid: Patterson House bill $8,283 + $2,596 (1/4) Central Office bill = $10,879

Line 4, R/E tax accrual: 9/12 Patterson House bill $6,212 + $1,947 (1/4) 9/12 Central Office bill = $8,159

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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) 425-4800 FAX #: (217) 425-8866

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-01-311-002	NE1/4 &E1/2 NW Blk 7 Kellars	$ 8,283.30	$ 8,283.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,283.30	$ 8,283.30

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 10/1/10 Ending: 9/30/11

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).

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	15,000	1990	$ 20,550	1
2					2
3	TOTALS	15,000		$ 20,550	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		1991	1991	$ 230,924	$ 5,773	40	$ 5,773	$	$ 116,466	4
5											5
6											6
7											7
8	Central Office		2005		119,594	3,326	39	3,326		8,015	8
	Improvement Type**										
9	Driveways			1991	16,799		10			16,799	9
10	Landscaping			1991	4,593		10			4,593	10
11	New floor/tile			1998	2,759		10			2,759	11
12	New carpet			2000	2,810		10			2,810	12
13	New roof			2007	11,410	571	20	571		2,377	13
14	Bathroom/kitchen remodeling			2007	3,223	215	15	215		806	14
15	(2) exit doors			2008	3,866	257	15	257		730	15
16	(3) outswing entry doors			2009	3,025	202	15	202		387	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		39	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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		$ 399,327	$ 10,360		$ 10,360	$	$ 155,781	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 10/1/10 Ending: 9/30/11

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	$ 118,002	$ 5,765	$ 5,765	$		$ 105,723	71
72	Current Year Purchases	2,504	197	197			197	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 120,506	$ 5,962	$ 5,962	$		$ 105,920	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)	$ 540,383	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,322	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 16,322	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)	$ 261,701	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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	Patient-Care	2006 Chevrolet Express	$ 540.48	$ 4,365	17
18					18
19					19
20					20
21	TOTAL		$ 540.48	$ 4,365	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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/11 (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	$ 1,957	$ 7,977	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	165,352	608,144	3
4	Supply Inventory (priced at)	2,548	7,898	4
5	Short-Term Investments			5
6	Prepaid Insurance	1,832	7,331	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	390,163	1,560,652	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 561,852	$ 2,192,002	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	276,599	276,599	14
15	Leasehold Improvements, at Historical Cost	3,134	187,845	15
16	Equipment, at Historical Cost	120,506	396,458	16
17	Accumulated Depreciation (book methods)	(253,686)	(577,752)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,232	10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,232)	(10,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **loan fees, net**	1,292	5,165	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 168,395	$ 308,865	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 730,247	$ 2,500,867	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,451	$ 22,381	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	70,500	282,002	29
30	Accrued Salaries Payable	5,264	21,473	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,228	12,914	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,159	33,610	32
33	Accrued Interest Payable	453	1,812	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Intercompany	(693,855)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (597,800)	$ 374,192	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	444,984	1,779,939	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)**	$ 444,984	$ 1,779,939	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (152,816)	$ 2,154,131	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 883,063	$ 346,736	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 730,247	$ 2,500,867	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 890,007	1
2	Restatements (describe):		2
3	Correct outstanding common stock	200	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 890,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	170,692	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	(177,836)	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)**	$ (7,144)	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)**	$ 883,063	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	$ 720,798	1
2	Discounts and Allowances for all Levels	(5,191)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 715,607	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	6,762	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,762	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	135,767	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135,767	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 858,136	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	147,295	31
32	Health Care	302,529	32
33	General Administration	151,960	33
	B. Capital Expense		
34	Ownership	36,252	34
	C. Ancillary Expense		
35	Special Cost Centers	3,398	35
36	Provider Participation Fee	40,727	36
	D. Other Expenses (specify):		
37	IL Replacement Tax	5,283	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 687,444	40
41	**Income before Income Taxes (line 30 minus line 40)****	170,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 170,692	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 Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	1,859	2,044	21,663	10.60	9
10	Activity Assistants	795	795	7,158	9.00	10
11	Social Service Workers	2,253	2,308	32,225	13.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,990	2,119	23,988	11.32	14
15	Cook Helpers/Assistants	987	1,031	9,028	8.76	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	4,173	4,328	37,759	8.72	18
19	Laundry					19
20	Administrator	451	520	14,270	27.44	20
21	Assistant Administrator					21
22	Other Administrative	1,000	1,040	43,466	41.79	22
23	Office Manager					23
24	Clerical	480	540	5,719	10.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	10,045	10,215	92,742	9.08	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,033	24,940	$ 288,018 *	$ 11.55	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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	25	$ 1,200	1, 3	35
36	Medical Director	$350/mo	4,200	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	155	5,422	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	15	676	10a, 3	43
44	Activity Consultant				44
45	Social Service Consultant	30	1,664	12, 3	45
46	Other(specify)				46
47	Psychologist Consultant	19	1,148	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)	244	$ 14,310		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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	50	$ 21,733
Daniel P. Caulkins	Administrative	50	21,733
Lora A. Dillman	Administrative		14,270
Jennifer Haseley	Office Assistant		5,719
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,455

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.	$ 8,895
Geisler Law Offices	Legal	117
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,012

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,996
Unemployment Compensation Insurance	2,196
FICA Taxes	21,544
Employee Health Insurance	9,450
Employee Meals	1,154
Illinois Municipal Retirement Fund (IMRF)*	
Long-Term Care Insurance	2,639
Employee Awards	56
Employee Medical Expenses	1,409
Other Employee Expenses	2,288
TOTAL (agree to Schedule V, line 22, col.8)	$ 46,732

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	
Health Care Worker Background Check	105
(Indicate # of checks performed 3)	
Patient Background Checks	
Dues and Subscriptions	1,284
Fees and Licenses	51
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,440

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	90
Seminar Expense	165
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 255

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 Patterson House **#** 0037341 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,727**
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. $ **3,398**
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 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.

Patterson House (# 0037341) 10/1/10 - 9/30/11

Page 3, Part V

Line 23 Inservice Training & Education

Consultants	472
	472

Line 25 Other Admin. Staff Transportation

Fuel	5,731
Mileage	4,865
Vehicle Maintenance	1,052
	11,648
Less special cost center - medically necessary transportation	(3,398)
	8,250

Page 6, Part VII, B

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

Regions Bank	13,796

The interest is allocated as follows:

Carlinville Estates	3,449
Emerald Estates	3,449
Marigold Estates	3,449
Patterson House	3,449

Page 6, Part VII, B

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

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

Carlinville Estates	119,594
Emerald Estates	119,594
Marigold Estates	119,594
Patterson House	119,594

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

Regions Bank	35,188

The interest is allocated as follows:

Carlinville Estates	8,797
Emerald Estates	8,797
Marigold Estates	8,797
Patterson House	8,797

Patterson House, Inc. 10/1/10 - 9/30/11
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (# 0037341)

Page 7, Part VII, C

Owners' Compensation
10/1/10 - 9/30/11

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House
Richard L. Grader	86,932	21,733	21,733	21,733	21,733
Daniel P. Caulkins	86,932	21,733	21,733	21,733	21,733
	173,864	43,466	43,466	43,466	43,466

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House, Inc. 10/1/10 - 9/30/11
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (# 0037341)

Owners' Compensation
10/1/10 - 9/30/11

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. 10/1/10 - 9/30/11
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (# 0037341)

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2011

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	172	43	43	43	43	1
Food Costs	1,274	318	318	319	319	2
Housekeeping Salaries	4,070	1,018	1,018	1,017	1,017	3
Housekeeping Supplies	363	90	91	91	91	3
Utilities	11,564	2,891	2,891	2,891	2,891	5
Maintenance	8,737	2,185	2,184	2,184	2,184	6
Administrative Salaries	253,819	63,454	63,455	63,455	63,455	17
Professional Services	30,047	7,512	7,511	7,512	7,512	19
Dues, Fees and Subscriptions	3,102	776	776	775	775	20
Contributions	6,150	1,537	1,537	1,538	1,538	20
Office Supplies	3,287	822	822	821	822	21
Other Office Expense	6,219	1,555	1,555	1,555	1,554	21
Postage	4,225	1,056	1,056	1,056	1,057	21
Telephone	12,610	3,152	3,153	3,153	3,152	21
Payroll Taxes	16,331	4,083	4,082	4,083	4,083	22
Group Health Insurance	37,800	9,450	9,450	9,450	9,450	22
Long-Term Care Insurance	10,555	2,639	2,639	2,638	2,639	22
Workers Comp Insurance	23,985	5,996	5,996	5,997	5,996	22
Business Meals	4,319	1,080	1,080	1,079	1,080	22
Entertainment	512	128	128	128	128	22
Other Employee Benefits	1,250	312	313	313	312	22
Inservice Training and Education	370	93	92	92	93	23
Travel and Seminars	2,821	706	705	705	705	24
Other Admin/Staff Transportation	10,594	2,648	2,649	2,649	2,648	25
Insurance	37,116	9,279	9,279	9,279	9,279	26
Depreciation	7,166	1,792	1,791	1,791	1,792	30
Interest Expense	4,247	1,062	1,062	1,062	1,061	32
Real Estate Taxes	10,411	2,602	2,603	2,603	2,603	33
Lease - Central Office	30,000	7,500	7,500	7,500	7,500	34
IL Replacement Tax	21,132	5,283	5,283	5,283	5,283	36
	564,248	141,062	141,062	141,062	141,062	

Patterson House, Inc. 10/1/10 - 9/30/11
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (# 0037341)

Page 9, Part IX

Mortgage

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

Regions Bank - balance @ 9/30/11	1,779,939
Carlinville Estates	444,985
Emerald Estates	444,985
Marigold Estates	444,985
Patterson House	444,984

Page 19, Part XVII

Line 21 Other Medical Services

HAB Aid training reimbursement	6,762

Line 28 Other Revenue

Earning Credits	4,209
Reimburse residents' travel	3,398
Workshop	128,160
	135,767

Facility fiscal year end is 9/30/11, tax year end is 12/31/11. Taxable income will not agree.

Page 23, Part XX, Line 12

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

SEE ACCOUNTANTS' COMPILATION REPORT