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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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) 423-6000
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 10/1/14 to 9/30/15 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. — Partner
(Firm Name & Address) Sikich LLP, 132 South Water St., Ste 300, Decatur IL 62523
(Telephone) (217) 423-6000 Fax # (217) 423-6100

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: 10/1/14 Ending: 9/30/15

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	13	ICF/DD 16 or Less	16	5,840	6
7	13	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	4,962			4,962	13
14	TOTALS	4,962			4,962	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.97%

D. How many bed-hold days during this year were paid by the Department?
158 (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 11/15/1991

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: 12/31/15 Fiscal Year: 9/30/15

* 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: 10/1/14 Ending: 9/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	27,043	2,108	1,378	30,529		30,529		30,529			1
2	Food Purchase		34,137		34,137		34,137		34,137			2
3	Housekeeping	35,160	1,698		36,858		36,858		36,858			3
4	Laundry		867		867		867		867			4
5	Heat and Other Utilities			21,299	21,299		21,299		21,299			5
6	Maintenance		2,232	12,827	15,059		15,059		15,059			6
7	Other (specify):* Garbage			3,146	3,146		3,146		3,146			7
8	TOTAL General Services	62,203	41,042	38,650	141,895		141,895		141,895			8
	B. Health Care and Programs											
9	Medical Director			3,150	3,150		3,150		3,150			9
10	Nursing and Medical Records	106,850	5,635	6,185	118,670		118,670		118,670			10
10a	Therapy			1,164	1,164		1,164		1,164			10a
11	Activities	33,282	2,577		35,859		35,859		35,859			11
12	Social Services	34,260		1,220	35,480		35,480		35,480			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			196,408	196,408		196,408	(196,408)				15
16	TOTAL Health Care and Programs	174,392	8,212	208,127	390,731		390,731	(196,408)	194,323			16
	C. General Administration											
17	Administrative	81,269			81,269		81,269		81,269			17
18	Directors Fees											18
19	Professional Services			11,198	11,198		11,198		11,198			19
20	Dues, Fees, Subscriptions & Promotions			2,033	2,033		2,033	(217)	1,816			20
21	Clerical & General Office Expenses		5,422	7,227	12,649		12,649		12,649			21
22	Employee Benefits & Payroll Taxes			56,516	56,516		56,516	(333)	56,183			22
23	Inservice Training & Education			532	532		532		532			23
24	Travel and Seminar			257	257		257		257			24
25	Other Admin. Staff Transportation			15,643	15,643	(1,636)	14,007		14,007			25
26	Insurance-Prop.Liab.Malpractice			8,802	8,802		8,802		8,802			26
27	Other (specify):*											27
28	TOTAL General Administration	81,269	5,422	102,208	188,899	(1,636)	187,263	(550)	186,713			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	317,864	54,676	348,985	721,525	(1,636)	719,889	(196,958)	522,931			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:** 10/1/14 **Ending:** 9/30/15

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			10,018	10,018		10,018	3,275	13,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,109	9,109		9,109	7,529	16,638			32
33	Real Estate Taxes			8,770	8,770		8,770		8,770			33
34	Rent-Facility & Grounds			8,700	8,700		8,700	(8,700)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* IL replacement tax			2,721	2,721		2,721	(2,721)				36
37	**TOTAL Ownership**			39,318	39,318		39,318	(617)	38,701			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,636	1,636		1,636			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,811	38,811		38,811		38,811			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			38,811	38,811	1,636	40,447		40,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	317,864	54,676	427,114	799,654		799,654	(197,575)	602,079			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: 10/1/14 Ending: 9/30/15

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	(196,408)	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	(151)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(482)	36		18
19	Entertainment	(333)	22		19
20	Contributions				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	(66)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,239)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,679)		$	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)	2,104	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,104		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (197,575)		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		$ 1,636	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)**			$ 1,636		47

SEE ACCOUNTANTS' COMPILATION REPORT

Patterson House

ID# 0037341

Report Period Beginning: 10/1/14

Ending: 9/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House # 0037341 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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):*	(196,408)	0	0	0	0	0	0	0	0	0	0	(196,408)	15
16	**TOTAL Health Care and Programs**	(196,408)	0	0	0	0	0	0	0	0	0	0	(196,408)	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	(217)	0	0	0	0	0	0	0	0	0	0	(217)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(333)	0	0	0	0	0	0	0	0	0	0	(333)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(550)	0	0	0	0	0	0	0	0	0	0	(550)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(196,958)	0	0	0	0	0	0	0	0	0	0	(196,958)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House # 0037341 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	3,275	0	0	0	0	0	0	0	0	0	3,275	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	7,529	0	0	0	0	0	0	0	0	0	7,529	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(8,700)	0	0	0	0	0	0	0	0	0	(8,700)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(2,721)	0	0	0	0	0	0	0	0	0	0	(2,721)	36
37	TOTAL Ownership	(2,721)	2,104	0	0	0	0	0	0	0	0	0	(617)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(199,679)	2,104	0	0	0	0	0	0	0	0	0	(197,575)	45

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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%	$ 2,078	$ 2,078	1
2	V	30	Depreciation		R&D LLP	100.00%	3,275	3,275	2
3	V	32	Interest		R&D LLP	100.00%	5,451	5,451	3
4	V	34	Rent	8,700	R&D LLP	100.00%		(8,700)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 8,700			$ 10,804	$ * 2,104	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 27,104	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See Attached	10	25.00	Wages	27,104	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	$ 54,208		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

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	Town & Country Bank		X	Mortgage - Refinanced		7/1/13	$ 486,000	$ 443,423	7/1/18	3.5000	$ 16,319	1
2	Town & Country Bank		X	Vehicle loan		11/14/11	22,500	1,171	11/14/15	3.9500	198	2
3	Related Parties	X		Interest Income						0.2200	(628)	3
4												4
5												5
	Working Capital											
6	Town & Country Bank		X	Working Capital		2/9/10		54,850		4.5000	761	6
7	Town & Country Bank		X	Interest Income							(12)	7
8												8
9	TOTAL Facility Related						$ 508,500	$ 499,444			$ 16,638	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 508,500	$ 499,444			$ 16,638	15

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

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

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: 10/1/14 Ending: 9/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 6,534	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 9,357	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,823	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 5,947	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.		$ 8,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	8,283	8
	2011	6,066	9
	2012	6,203	10
	2013	6,445	11
	2014	6,475	12

Line 2, R/E taxes paid: Patterson House bill $6,475 + $2,882 Central Office bill = $9,357

Line 4, R/E tax accrual: 9/12 Patterson House bill $4,856 + Central Office bill $1,091 = $5,947

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Patterson House COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0037341

CONTACT PERSON REGARDING THIS REPORT David W. White, C.P.A.

TELEPHONE (217) 423-6000 FAX #: (217) 423-6100

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-01-311-002	NE1/4&1/2NW1/4BLK 7 Kellars	$ 6,475.00	$ 6,475.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,475.00	$ 6,475.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 10/1/14 Ending: 9/30/15

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).

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	1991	$ 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: 10/1/14 Ending: 9/30/15

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	39	$ 5,773	$	$ 139,559	4
5											5
6											6
7											7
8	Central Office		2005		119,594	3,275	39	3,275		25,074	8
	Improvement Type**										
9	Driveways			1991	16,799		40			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	570	20	570		4,659	13
14	Bathroom/kitchen remodeling			2007	3,223	215	15	215		1,665	14
15	(2) exit doors			2008	3,866	258	15	258		1,761	15
16	(3) outswing entry doors			2009	3,025	202	15	202		1,193	16
17	(2) Furnaces			2013	7,991	205	39	205		478	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 - tracklights and receptacles			2009	324	19	19	19		121	30
31	Central Office - new roof			2012	4,700	140	140	140		396	31
32	Central Office - permanent landscaping			2015	1,805	17		17		17	32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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)		$ 413,823	$ 10,674		$ 10,674	$	$ 201,884	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: 10/1/14 Ending: 9/30/15

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	$ 125,633	$ 2,400	$ 2,400	$	7	$ 122,705	71
72	Current Year Purchases	798	219	219		7	219	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 126,431	$ 2,619	$ 2,619	$		$ 122,924	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)	$ 560,804	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,293	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,293	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)	$ 324,808	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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 Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/15 (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	$ (22,739)	$ (78,104)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	102,810	411,061	3
4	Supply Inventory (priced at)	2,565	11,480	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,800	9,654	7
8	Accounts Receivable (owners or related parties)	461,399	1,591,032	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 546,835	$ 1,945,123	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	284,590	284,590	14
15	Leasehold Improvements, at Historical Cost	9,639	261,983	15
16	Equipment, at Historical Cost	126,431	566,733	16
17	Accumulated Depreciation (book methods)	(296,618)	(783,854)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan fees	2,515	8,672	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 147,107	$ 358,674	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 693,942	$ 2,303,797	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,000	$ 72,892	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,371	45,595	30
31	Accrued Taxes Payable (excluding real estate taxes)	688	2,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,947	35,046	32
33	Accrued Interest Payable	948	3,271	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(852,811)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (814,857)	$ 159,177	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,683	19,597	39
40	Mortgage Payable	498,272	1,718,181	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)**	$ 503,955	$ 1,737,778	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (310,902)	$ 1,896,955	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,004,844	$ 406,842	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 693,942	$ 2,303,797	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Patterson House **#** 0037341 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,003,326	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,003,326	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	48,318	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	(46,800)	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)**	$ 1,518	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)**	$ 1,004,844	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 645,303	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 645,303	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	2,378	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,378	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 - PG 31	200,291	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 200,291	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 847,972	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	141,895	31
32	Health Care	390,731	32
33	General Administration	187,263	33
	B. Capital Expense		
34	Ownership	39,318	34
	C. Ancillary Expense		
35	Special Cost Centers	1,636	35
36	Provider Participation Fee	38,811	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 799,654	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,318	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,318	43

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	98	112	1,185	10.58	9
10	Activity Assistants	2,839	2,853	32,096	11.25	10
11	Social Service Workers	2,206	2,270	34,260	15.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,800	1,934	22,208	11.48	14
15	Cook Helpers/Assistants	330	464	4,835	10.42	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,629	3,861	35,161	9.11	18
19	Laundry					19
20	Administrator	539	603	53,794	89.21	20
21	Assistant Administrator					21
22	Other Administrative	1,114	1,206	18,243	15.13	22
23	Office Manager					23
24	Clerical	554	603	9,232	15.31	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)	10,279	10,585	106,850	10.09	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,388	24,491	$ 317,864 *	$ 12.98	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	28	$ 1,378	1,3	35
36	Medical Director	$350/month	4,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	118	4,732	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant			10a,3	40
41	Occupational Therapy Consultant			10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	229	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,220	10a,3	45
46	Other(specify)				46
47	Psychologist Consultant	19	935	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	194	$ 12,694		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 Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	50	$ 26,897
Daniel P. Caulkins	Administrative	50	26,897
Lora A. Dillman	Administrative	0	18,243
Jennifer Haseley	Office Assistant	0	9,232
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,269

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
Featherstun	Legal	$ 359
George Davis	CPR Instructor	312
Stacey Savidge	Appraiser	87
Sikich LLP	CPA	10,440
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 11,198

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,625
Unemployment Compensation Insurance	2,467
FICA Taxes	22,728
Employee Health Insurance	13,460
Employee Meals	1,217
Illinois Municipal Retirement Fund (IMRF)*	
Long Term Care Insurance	1,882
Employee Medical Expenses	746
Other Employee Expenses	5,058
TOTAL (agree to Schedule V, line 22, col.8)	$ 56,183

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	264
Health Care Worker Background Check (Indicate # of checks performed 9)	
Patient Background Checks	
Dues and subscriptions	1,111
Fees and licenses	441
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,816

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	257
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 257

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/14 Ending: 9/30/15

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:** 10/1/14 **Ending:** 9/30/15

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? **10 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. $ **38,811**
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. $ **1,636**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, Part V

Line 23 - Inservice Training & Education

Consultants	532
	532

Line 25 - Other Admin. Staff Transportation

Fuel	4,408
Mileage	6,211
Vehicle Maintenance	5,024
Subtotal	15,643
Less special cost center - medically necessary transportation	(1,636)
	14,007

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc.

Carlinville Estates		10/1/14 - 9/30/15
Emerald Estates		
Marigold Estates		
Patterson House	(#0037341)	

Page 6, Part VII, Table B

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

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

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

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

Town & Country Bank	7,167

The interest is allocated as follows:

Carlinville Estates	1,935
Emerald Estates	1,218
Marigold Estates	1,935
Patterson House	2,078
	7,167

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Page 6, Part VII, B

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

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

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

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

Town & Country Bank	18,797

The interest is allocated as follows:

Carlinville Estates	5,075
Emerald Estates	3,196
Marigold Estates	5,075
Patterson House	5,451
	18,797

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc. 10/1/14 - 9/30/15
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

Page 7, Part VII, C

Owners' Compensation
10/1/14 - 9/30/15

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House
Richard L. Grader	93,461	25,234	15,888	25,234	27,104
Daniel P. Caulkins	93,461	25,234	15,888	25,234	27,104
	186,922	50,468	31,776	50,468	54,208

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc. 10/1/14 - 9/30/15
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

Owners' Compensation
10/1/14 - 9/30/15

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.

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

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

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2015
The group consists of four DD homes - All with 16 beds.
All costs of the central office and common costs are allocated as follows:
Carlinvile - 27%, Emerald - 17%, Marigold - 27%, Patterson - 29%

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

	Total Expense	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	Line Ref
Food costs	959	259	163	259	278	1
Housekeeping Supplies	234	63	40	63	68	3
Utilities	13,454	3,632	2,288	3,632	3,902	5
Maintenance	13,173	3,557	2,239	3,557	3,820	6
Nondepreciable equipment (consumable items)	270	73	46	73	78	7
Nursing Consultant fees	0	0	0	0	0	10
Administrative Salaries	213,316	57,595	36,264	57,595	61,862	17
Professional Services	38,615	10,426	6,565	10,426	11,198	19
Dues, Fees and Subscriptions	2,784	752	473	752	807	20
Contributions	0	0	0	0	0	20
Office Supplies	3,917	1,058	666	1,058	1,135	21
Other Office Expense	5,463	1,475	929	1,475	1,584	21
Postage	6,354	1,716	1,080	1,715	1,843	21
Telephone	11,653	3,146	1,981	3,146	3,380	21
Payroll Taxes	17,064	4,607	2,900	4,607	4,948	22
Group Health Insurance	113,336	30,601	19,267	30,601	32,867	22
Long-Term Care Insurance	6,491	1,753	1,103	1,753	1,882	22
Workers Comp Insurance	26,306	7,103	4,472	7,103	7,628	22
Business Meals	2,747	742	467	742	796	22
Entertainment	1,147	309	195	309	334	22
Other Employee Benefits	17,441	4,709	2,965	4,709	5,058	22
Inservice Training & Education	1,833	495	311	495	532	23
Travel and seminars	275	74	47	74	80	24
Other Admin/Staff Transportation	30,324	8,187	5,155	8,187	8,795	25

Insurance	30,353	8,195	5,160	8,195	8,803	26
Depreciation	4,193	1,132	713	1,132	1,216	30
Interest Expense	31,411	8,481	5,340	8,481	9,109	32
Real Estate Taxes	9,697	2,618	1,648	2,618	2,813	33
Lease - Central Office	30,000	8,100	5,100	8,100	8,700	34
IL replacement tax	7,719	2,084	1,312	2,084	2,239	36
	640,529	172,942	108,889	172,941	185,755	

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc. 10/1/14 - 9/30/15
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

Page 9, Part IX

Mortgage

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

Town & Country Bank - balance @ 9/30/15	1,529,044

Carlinville Estates	412,842
Emerald Estates	259,937
Marigold Estates	412,842
Patterson House	443,423

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	2,378

Line 28, Other Revenue

Earning Credits	2,247
Residents' travel reimbursement	1,636
Workshop	196,408
	200,291

**Facility fiscal year end is 9/30/15, tax year end is 12/31/15.
Taxable income will not agree.

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

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 INDEPENDENT ACCOUNTANT'S COMPILATION REPORT