

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0039354</u></p> <p>Facility Name: <u>Emerald Estates</u></p> <p>Address: <u>1577 East Myrtle</u> <u>Canton</u> <u>61520</u> Number City Zip Code</p> <p>County: <u>Fulton</u></p> <p>Telephone Number: <u>309-647-6604</u> Fax # <u>309-647-0440</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/26/94</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David W. White</u> Telephone Number: <u>217-423-6000</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/16</u> to <u>9/30/17</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="3" style="width:15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Richard L. Grader</u> (Date) _____</td> </tr> <tr> <td>(Title) <u>President</u></td> </tr> <tr> <td rowspan="5" style="width:15%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>David W. White, C.P.A.</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Sikich LLP</u> <u>132 S. Water St., Ste 300, Decatur IL, 62523</u></td> </tr> <tr> <td>(Telephone) <u>217-423-6000</u> Fax # <u>217-423-6100</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Richard L. Grader</u> (Date) _____	(Title) <u>President</u>	Paid Preparer	(Signed) _____	(Print Name and Title) <u>David W. White, C.P.A.</u> <u>Partner</u>	(Firm Name & Address) <u>Sikich LLP</u> <u>132 S. Water St., Ste 300, Decatur IL, 62523</u>	(Telephone) <u>217-423-6000</u> Fax # <u>217-423-6100</u>	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
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Facility Name & ID Number Emerald Estates

0039354 Report Period Beginning: 10/1/16 Ending: 9/30/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,628			5,628	13
14	TOTALS	5,628			5,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.37%

D. How many bed reserve days during this year were paid by the Department?
120 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/93 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 9/30/17

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/16 Ending: 9/30/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	25,072	2,401	1,375	28,848		28,848		28,848		1
2	Food Purchase		33,840		33,840		33,840		33,840		2
3	Housekeeping	40,877	3,575		44,452		44,452		44,452		3
4	Laundry		1,058		1,058		1,058		1,058		4
5	Heat and Other Utilities			15,980	15,980		15,980		15,980		5
6	Maintenance		1,642	9,084	10,726		10,726		10,726		6
7	Other (specify):* Garbage service			1,717	1,717		1,717		1,717		7
8	TOTAL General Services	65,949	42,516	28,156	136,621		136,621		136,621		8
	B. Health Care and Programs										
9	Medical Director			1,250	1,250		1,250		1,250		9
10	Nursing and Medical Records	112,279	7,538	10,724	130,541		130,541		130,541		10
10a	Therapy			476	476		476		476		10a
11	Activities	28,663	2,866		31,529		31,529		31,529		11
12	Social Services	44,765		2,200	46,965		46,965		46,965		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Workshop			225,507	225,507		225,507	(225,507)			15
16	TOTAL Health Care and Programs	185,707	10,404	240,157	436,268		436,268	(225,507)	210,761		16
	C. General Administration										
17	Administrative	23,618			23,618		23,618		23,618		17
18	Directors Fees										18
19	Professional Services			8,551	8,551		8,551		8,551		19
20	Dues, Fees, Subscriptions & Promotions			1,178	1,178		1,178	(373)	805		20
21	Clerical & General Office Expenses		5,812	4,299	10,111		10,111		10,111		21
22	Employee Benefits & Payroll Taxes			38,868	38,868		38,868	(590)	38,278		22
23	Inservice Training & Education			699	699		699		699		23
24	Travel and Seminar			75	75		75		75		24
25	Other Admin. Staff Transportation			9,088	9,088	(475)	8,613		8,613		25
26	Insurance-Prop.Liab.Malpractice			4,016	4,016		4,016		4,016		26
27	Other (specify):* Contributions			1,999	1,999		1,999	(1,999)			27
28	TOTAL General Administration	23,618	5,812	68,773	98,203	(475)	97,728	(2,962)	94,766		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	275,274	58,732	337,086	671,092	(475)	670,617	(228,469)	442,148		29

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

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

Facility Name & ID Number

Emerald Estates

#0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			6,807	6,807		6,807	10,530	17,337			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,085	6,085		6,085	3,275	9,360			32
33	Real Estate Taxes			14,428	14,428		14,428		14,428			33
34	Rent-Facility & Grounds			33,696	33,696		33,696	(33,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State repl tax			580	580		580	(580)				36
37	TOTAL Ownership			61,596	61,596		61,596	(20,471)	41,125			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					475	475		475			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,777	36,777		36,777		36,777			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,777	36,777	475	37,252		37,252			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	275,274	58,732	435,459	769,465		769,465	(248,940)	520,525			45

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

Emerald Estates

ID# 0039354

Report Period Beginning: 10/1/16

Ending: 9/30/17

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 Emerald Estates# 0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(225,507)	0	0	0	0	0	0	0	0	0	0	(225,507)	15
16	TOTAL Health Care and Programs	(225,507)	0	0	0	0	0	0	0	0	0	0	(225,507)	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	(373)	0	0	0	0	0	0	0	0	0	0	(373)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(590)	0	0	0	0	0	0	0	0	0	0	(590)	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):*	(1,999)	0	0	0	0	0	0	0	0	0	0	(1,999)	27
28	TOTAL General Administration	(2,962)	0	0	0	0	0	0	0	0	0	0	(2,962)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(228,469)	0	0	0	0	0	0	0	0	0	0	(228,469)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	10,530	0	0	0	0	0	0	0	0	0	10,530	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	3,275	0	0	0	0	0	0	0	0	0	3,275	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(33,696)	0	0	0	0	0	0	0	0	0	(33,696)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(580)	0	0	0	0	0	0	0	0	0	0	(580)	36
37	TOTAL Ownership	(580)	(19,891)	0	0	0	0	0	0	0	0	0	(20,471)	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)	(229,049)	(19,891)	0	0	0	0	0	0	0	0	0	(248,940)	45

Facility Name & ID Number

Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Richard L. Grader	100	Carlville Estates	Carlville	TwoCan, Inc	Decatur	Landlord
		Emerald Estates	Canton	RLG Real Estate, LLC	Decatur	Landlord
		Marigold Estates	Pekin			
		Patterson House	Sullivan			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	TwoCan, Inc	100.00%	\$ 6,969	\$ 6,969	1
2	V	32 Interest		TwoCan, Inc	100.00%	937	937	2
3	V	34 Rent	29,496	TwoCan, Inc	100.00%		(29,496)	3
4	V	30 Depreciation		RLG Real Estate, LLC	100.00%	3,561	3,561	4
5	V	32 Interest		RLG Real Estate, LLC	100.00%	2,338	2,338	5
6	V	34 Rent	4,200	RLG Real Estate, LLC	100.00%		(4,200)	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 33,696			\$ 13,805	\$ * (19,891)	14

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

Facility Name & ID Number

Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Richard L. Grader	President	Administration	100.00	See attached	10	20.00	Wages	\$ 12,278	17,1	1
2	Daniel P. Caulkins		Administration		See attached	10	20.00	Wages	2,408	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	\$ 14,686		13

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

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

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Central Office - Patterson House, Inc
 Street Address 636 West Imboden
 City / State / Zip Code Decatur IL 62521
 Phone Number (217) 422-6510
 Fax Number (217) 422-6819

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

Facility Name & ID Number

Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Hickory Point Bank		X	Mortgage - Refinanced		9/16/16	\$ 389,200	\$ 356,501	9/16/19	3.6500	\$ 7,039	1						
2	Related Parties	X		Interest Income						0.2200	(372)	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Hickory Point Bank		X	Working Capital		9/16/16	98,000	89,303		3.5000	2,701	6						
7	Hickory Point Bank		X	Interest Income							(7)	7						
8												8						
9	TOTAL Facility Related						\$ 487,200	\$ 445,804			\$ 9,361	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 487,200	\$ 445,804			\$ 9,361	15						

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

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

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

Facility Name & ID Number **Emerald Estates**# **0039354**

Report Period Beginning:

10/1/16

Ending:

9/30/17**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2016 report.				\$	10,960	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.)				\$	13,934	2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,974	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	11,453	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.				\$	14,427	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2012	10,811	8			
	2013	11,125	9			
	2014	11,207	10			
	2015	11,801	11			
	2016	12,416	12			
Line 2, R/E taxes paid: Emerald Estates bill \$12,416 + \$1,518 Central Office bill = \$13,934				13	FOR BHF USE ONLY	
Line 4, R/E tax accrual: 9/12 Emerald Estates bill \$9,312 + Central Office bill \$2,141 = \$11,453						
				13	FROM R. E. TAX STATEMENT FOR 2016	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Estates COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0039354

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 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-08-25-102-007</u>	<u>Sect/Lot: 07 Village Square Sub</u>	\$ <u>453.64</u>	\$ <u>453.64</u>
2. <u>09-08-25-102-008</u>	<u>Sect/Lot: 08 Village Square Sub</u>	\$ <u>453.64</u>	\$ <u>453.64</u>
3. <u>09-08-25-102-009</u>	<u>Sect/Lot: 09 Village Square Sub</u>	\$ <u>11,508.20</u>	\$ <u>11,508.20</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>12,415.48</u>	\$ <u>12,415.48</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Emerald Estates

0039354 Report Period Beginning:

10/1/16 Ending:

9/30/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 29,642, 1993, \$ 18,934, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 29,642, (blank), \$ 18,934, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1993	1989	\$ 273,944	\$	39	\$ 6,970	\$ 6,970	\$ 162,727	4
5										5
6										6
7										7
8	Central Office	2005		132,849		39	3,562	3,562	13,531	8
	Improvement Type**									
9	Remodeling, flooring		1996	10,099		20			10,099	9
10	Remodeling, flooring		1996	6,110	157	20	157		3,303	10
11	Driveway		1999	11,000		20			11,000	11
12	Water Heater		2001	2,000		39			2,000	12
13	Carpet		2004	3,007		7			3,007	13
14	New sinks and faucets		2004	1,190		20			1,190	14
15	Bathroom remodeling - new plumbing, flooring, walls		2006	12,862	330	7	330		3,573	15
16	Bathroom remodeling - new plumbing, flooring, walls		2007	6,708	171	7	171		1,777	16
17	Carpet - Entire facility		2012	8,188	1,170	5	1,170		6,434	17
18	Roof		2013	20,197	518	39	518		2,028	18
19	Ramp, deck, sidewalk		2014	3,819	98	39	98		302	19
20	Shower unit with grab bars, new pedestal lavatory, faucet, drain.		2016	3,260	83	39	83		132	20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	Central office - track lights & receptacles		2009	216	9	20	9		76	31
32	New roof		2012	3,133	67	39	67		326	32
33	Permanent landscaping		215	1,204	101	10	101		211	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 499,786	\$ 2,704		\$ 13,236	\$ 10,532	\$ 221,716	70

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

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

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	\$ 93,964	\$ 3,510	\$ 3,510	\$		\$ 88,800	71
72	Current Year Purchases	2,750	22	22			22	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 96,714	\$ 3,532	\$ 3,532	\$		\$ 88,822	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	Facility	2011 Ford E350 Van	2011	\$ 34,164	\$ 569	\$ 569	\$	5	\$ 34,164	76
77										77
78										78
79										79
80	TOTALS			\$ 34,164	\$ 569	\$ 569	\$		\$ 34,164	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)	\$ 649,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,805	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,337	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,532	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 344,702	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning: 10/1/16

Ending: 9/30/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,876	\$ 56,193	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	113,640	589,504	3
4	Supply Inventory (priced at cost)	1,332	5,566	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,165	36,893	7
8	Accounts Receivable (owners or related parties)	361,845	2,584,610	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 489,858	\$ 3,272,766	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		307,160	14
15	Leasehold Improvements, at Historical Cost	92,993	303,551	15
16	Equipment, at Historical Cost	130,877	660,871	16
17	Accumulated Depreciation (book methods)	(168,444)	(885,754)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 55,426	\$ 406,378	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 545,284	\$ 3,679,144	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,370	\$ 95,502	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,375	61,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	423	3,003	31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,453	39,545	32
33	Accrued Interest Payable	506	3,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Intercompany</u>	942,341		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 979,468	\$ 203,127	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		32,675	39
40	Mortgage Payable	445,804	3,184,314	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)	\$ 445,804	\$ 3,216,989	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,425,272	\$ 3,420,116	46
47	TOTAL EQUITY(page 18, line 24)	\$ (879,988)	\$ 259,028	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 545,284	\$ 3,679,144	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (906,785)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (906,785)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,790	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	(46,993)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,797	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)	\$ (879,988)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning: 10/1/16

Ending:

9/30/17

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 616,594	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 616,594	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	434	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 434	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	<u>See attached schedule</u>	226,227	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 226,227	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 843,255	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	136,621	31
32	Health Care	436,268	32
33	General Administration	97,728	33
B. Capital Expense			
34	Ownership	61,596	34
C. Ancillary Expense			
35	Special Cost Centers	475	35
36	Provider Participation Fee	36,777	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 769,465	40
41	Income before Income Taxes (line 30 minus line 40)**	73,790	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,790	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 616,594	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)	\$ 616,594	49

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

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

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

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

Facility Name & ID Number Emerald Estates

0039354

Report Period Beginning:

10/1/16

Ending:

9/30/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	898	8,521	9.49	9
10	Activity Assistants	2,102	20,142	9.58	10
11	Social Service Workers	2,641	44,765	16.52	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,425	17,841	11.42	14
15	Cook Helpers/Assistants	897	7,231	8.06	15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	4,074	40,877	9.43	18
19	Laundry				19
20	Administrator	273	2,877	9.79	20
21	Assistant Administrator				21
22	Other Administrative	269	14,686	50.47	22
23	Office Manager				23
24	Clerical	274	6,055	20.81	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	11,793	112,279	9.45	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	24,646	275,274 *	10.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	28	\$ 1,375	1,3 35
36	Medical Director	\$100/mo	1,250	9,3 36
37	Medical Records Consultant			37
38	Nurse Consultant	264	9,883	10,3 38
39	Pharmacist Consultant	1	20	10a,3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	28	2,200	12 45
46	Other(specify)			46
47	Psychologist Consultant	6	456	10a,3 47
48				48
49	TOTAL (lines 35 - 48)	327	\$ 15,184	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Richard Grader	Administrative	100	\$ 12,278	Workers' Compensation Insurance	\$ 3,865	IDPH License Fee	\$	
Daniel Caulkins	Administrative		2,408	Unemployment Compensation Insurance	3,207	Advertising: Employee Recruitment	40	
Jennifer Haseley	Office Assistant		6,055	FICA Taxes	19,838	Health Care Worker Background Check		
Nicki Palmer	Administrative		2,877	Employee Health Insurance	7,744	(Indicate # of checks performed)		
				Employee Meals	905	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	222	
				Employee Medical Expenses	50	Fees and licenses	543	
				Other employee expense	2,669			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 23,618					
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				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Featherstun, Postlewait et al	Legal		\$ 589			\$	Out-of-State Travel	\$
Sikich	CPA		6,061					
Barnhart, Tisman, & Lane LTD	Legal		1,901				In-State Travel	75
							Emerald Estates to Millikin University	
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	(
(For legal fee disclosure, see page 39 of instructions)			\$ 8,551				(agree to Sch. V,	
							line 24, col. 8)	\$
							TOTAL	75

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (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. \$ 36,777
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 475
 - 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? _____
Firm Name: No
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

Patterson House, Inc.		
Carlenville Estates		10/1/16 - 9/30/17
Emerald Estates	(#0039354)	
Marigold Estates		
Patterson House		

Page 6, Part VII, Table B

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

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

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

Interest accrued by TwoCan, Inc. on its mortgage was:

Hickory Point Bank:	5,891
---------------------	-------

The interest is allocated as follows:

Carlenville Estates	1,607
Emerald Estates	937
Marigold Estates	1,607
Patterson House	<u>1,740</u>
	<u><u>5,891</u></u>

Patterson House, Inc.	10/1/16 - 9/30/17
Carlenville Estates	
Emerald Estates	(#0039354)
Marigold Estates	
Patterson House	

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability corporation, Richard Grader Real Estate LLC. Richard Grader Real Estate LLC has the same shareholders as Patterson House, Inc.

Richard Grader Real Estate, LLC has the following basis in the building:

 Carlenville Estates
 Emerald Estates
 Marigold Estates
 Patterson House

Interest accrued by Richard Grader Real Estate, LLC on its mortgage was as follows:

Hickory Point Bank	<u>14,696</u>
--------------------	---------------

The interest is allocated as follows:

Carlenville Estates	4,008
Emerald Estates	2,338
Marigold Estates	4,008
Patterson House	<u>4,342</u>
	<u><u>14,696</u></u>

Patterson House, Inc.
 Carlinville Estates
 Emerald Estates (#0039354)
 Marigold Estates
 Patterson House

10/1/16 - 9/30/17

Page 7, Part VII, C

Owners' Compensation
 10/1/16 - 9/30/17

	<u>Total Compensation</u>	<u>Carlinville Estates</u>	<u>Emerald Estates</u>	<u>Marigold Estates</u>	<u>Patterson House</u>	<u>Elin House (CILA)</u>	<u>Greykin House (CILA)</u>
Richard L. Grader	87,700	21,048	12,278	21,048	22,802	4,385	6,139
Daniel P. Caulkins**	<u>17,202</u>	<u>4,128</u>	<u>2,408</u>	<u>4,128</u>	<u>4,472</u>	<u>861</u>	<u>1,205</u>
	<u>104,902</u>	<u>25,176</u>	<u>14,686</u>	<u>25,176</u>	<u>27,274</u>	<u>5,246</u>	<u>7,344</u>

** Daniel P. Caulkins was 50% owner through 9/16/16. This compensation was paid after he was 50% owner, on 12/31/2016.
 Richard Grader became 100% owner on 9/16/16.

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

(#0039354)

10/1/16 - 9/30/17

Owners' Compensation
10/1/16 - 9/30/17

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

Operations of the facilities
Supervising employees
Dealing with consultants
Buying supplies
Inspecting the facilities
Locating residents
Dealing with residents' families
Dealing with government agencies

Reviewing vendor invoices
Paying invoices
Dealing with local day program agencies
Attending employee meetings
Recruiting employees
Dealing with employee complaints

The above duties are not all encompassing.

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

(#0039354)

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2017

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

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

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

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

	Total Expense	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	CILA Homes	Line Ref
Food costs	1,362	327	191	327	354	163	1
Housekeeping Supplies	211	50	30	50	55	26	3
Utilities	10,788	2,589	1,510	2,589	2,805	1,295	5
Maintenance	11,530	2,767	1,614	2,767	2,998	1,384	6
Nondepreciable equipment (consumable items)	0	0	0	0	0	0	7
Nursing Consultant fees	320	77	45	77	83	38	10
Administrative Salaries	125,383	30,092	17,554	30,092	32,599	15,046	17
Professional Services	40,654	9,757	5,692	9,757	10,570	4,878	19
Dues, Fees and Subscriptions	3,850	924	539	924	1,001	462	20
Contributions	14,278	3,427	1,999	3,427	3,712	1,713	20
Office Supplies	4,087	981	572	981	1,063	490	21
Other Office Expense	662	159	93	159	172	79	21
Postage	2,220	533	311	533	577	266	21
Telephone	8,200	1,968	1,148	1,968	2,132	984	21
Payroll Taxes	11,530	2,767	1,614	2,767	2,998	1,384	22
Group Health Insurance	100,218	24,052	14,031	24,052	26,057	12,026	22
Long-Term Care Insurance	0	0	0	0	0	0	22
Workers Comp Insurance	27,808	6,674	3,893	6,674	7,230	3,337	22
Business Meals	5,378	1,291	753	1,291	1,398	645	22
Entertainment	4,217	1,012	590	1,012	1,097	506	22
Other Employee Benefits	15,693	3,766	2,197	3,766	4,080	1,882	22
Inservice Training & Education	1,573	377	220	377	409	190	23
Travel and seminars	0	0	0	0	0	0	24
Other Admin/Staff Transportation	33,373	8,010	4,672	8,010	8,677	4,004	25
Insurance	36,231	8,695	5,072	8,695	9,420	4,349	26
Depreciation	2,291	550	321	550	595	275	30
Interest Expense	46,792	11,230	6,551	11,230	12,166	5,615	32
Real Estate Taxes	10,200	2,448	1,428	2,448	2,652	1,224	33
Lease - Central Office	27,500	6,600	3,850	6,600	7,150	3,300	34
IL replacement tax	4,145	995	580	995	1,078	497	36
	<u>550,494</u>	<u>132,118</u>	<u>77,070</u>	<u>132,118</u>	<u>143,128</u>	<u>66,058</u>	

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc. 10/1/16 - 9/30/17
Carlinville Estates
Emerald Estates (#0039354)
Marigold Estates
Patterson House

Page 9, Part IX

Mortgage

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

Balance @ 9/30/17 2,546,435

Carlinville Estates	611,144
Emerald Estates	356,501
Marigold Estates	611,144
Patterson House	662,073

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Emerald Estates (#0039354)

10/1/16 - 9/31/17

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>434</u>
--------------------------------	------------

Line 28, Other Revenue

Social Security	-
Earning Credits	172
Residents' travel reimbursement	475
Gain on asset disposal	70
Miscellaneous income	3
Workshop	<u>225,507</u>
	226,227

**Facility fiscal year end is 9/30/17, tax year end is 12/31/17.

Taxable income will not agree.

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Emerald Estates (#0039354)

10/1/16 - 9/30/17

Page 22, Part XX, Line 12

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

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT