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.

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	PROPRIETARY	GOVERNMENTAL
[ ] 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 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 10/01/16 to 9/30/17 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) Richard L. Grader
	(Title) President
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title) David W. White, C.P.A. Partner
	(Firm Name & Address) Sikich LLP 132 S. 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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	2	3	4	5	
	Level of Care	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	5,375			5,375	13
14	TOTALS	5,375			5,375	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.04%

D. How many bed reserve days during this year were paid by the Department?
71 (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 [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: 12/31/17 Fiscal Year: 9/30/17

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

Facility Name & ID Number Patterson House # 0037341 **Report Period Beginning:** 10/01/16 **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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	31,223	925	1,806	33,954		33,954		33,954			1
2	Food Purchase		33,782		33,782		33,782		33,782			2
3	Housekeeping	39,291	3,730		43,021		43,021		43,021			3
4	Laundry		690		690		690		690			4
5	Heat and Other Utilities			19,494	19,494		19,494		19,494			5
6	Maintenance		3,858	18,232	22,090		22,090		22,090			6
7	Other (specify):* Garbage			2,494	2,494		2,494		2,494			7
8	**TOTAL General Services**	70,514	42,985	42,026	155,525		155,525		155,525			8
	B. Health Care and Programs											
9	Medical Director			7,142	7,142		7,142		7,142			9
10	Nursing and Medical Records	134,206	5,638	13,964	153,808		153,808		153,808			10
10a	Therapy			2,222	2,222		2,222		2,222			10a
11	Activities	28,863	2,307		31,170		31,170		31,170			11
12	Social Services	44,015	1,030		45,045		45,045		45,045			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			196,400	196,400		196,400	(196,400)				15
16	**TOTAL Health Care and Programs**	207,084	8,975	219,728	435,787		435,787	(196,400)	239,387			16
	C. General Administration											
17	Administrative	45,279			45,279		45,279		45,279			17
18	Directors Fees											18
19	Professional Services			12,135	12,135		12,135		12,135			19
20	Dues, Fees, Subscriptions & Promotions			1,831	1,831		1,831	(478)	1,353			20
21	Clerical & General Office Expenses		5,632	4,989	10,621		10,621		10,621			21
22	Employee Benefits & Payroll Taxes			58,951	58,951		58,951	(1,096)	57,855			22
23	Inservice Training & Education			418	418		418		418			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			16,820	16,820	(553)	16,267		16,267			25
26	Insurance-Prop.Liab.Malpractice			7,458	7,458		7,458		7,458			26
27	Other (specify):* Contributions			3,713	3,713		3,713	(3,713)				27
28	**TOTAL General Administration**	45,279	5,632	106,315	157,226	(553)	156,673	(5,287)	151,386			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	322,877	57,592	368,069	748,538	(553)	747,985	(201,687)	546,298			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.

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			11,681	11,681		11,681	3,562	15,243			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,299	11,299		11,299	6,083	17,382			32
33	Real Estate Taxes			9,748	9,748		9,748		9,748			33
34	Rent-Facility & Grounds			7,800	7,800		7,800	(7,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State repl tax			1,078	1,078		1,078	(1,078)				36
37	TOTAL Ownership			41,606	41,606		41,606	767	42,373			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					553	553		553			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,366	35,366		35,366		35,366			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,366	35,366	553	35,919		35,919			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	322,877	57,592	445,041	825,510		825,510	(200,920)	624,590			45

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(196,400)	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	(414)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,096)	22		19
20	Contributions	(3,713)	27		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	(64)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,078)	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)**	$ (202,765)		$	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)	1,845	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,845		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (200,920)		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		$ 553	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)**			$ 553		47

STATE OF ILLINOIS

Patterson House

ID# 0037341

Report Period Beginning: 10/01/16

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
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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: 10/01/16 Ending: 9/30/17

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

	Operating Expenses A. General Services	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)	
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):*	(196,400)	0	0	0	0	0	0	0	0	0	0	(196,400)	15
16	**TOTAL Health Care and Programs**	(196,400)	0	0	0	0	0	0	0	0	0	0	(196,400)	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	(478)	0	0	0	0	0	0	0	0	0	0	(478)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,096)	0	0	0	0	0	0	0	0	0	0	(1,096)	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):*	(3,713)	0	0	0	0	0	0	0	0	0	0	(3,713)	27
28	**TOTAL General Administration**	(5,287)	0	0	0	0	0	0	0	0	0	0	(5,287)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(201,687)	0	0	0	0	0	0	0	0	0	0	(201,687)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	3,562	0	0	0	0	0	0	0	0	0	3,562	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,083	0	0	0	0	0	0	0	0	0	6,083	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(7,800)	0	0	0	0	0	0	0	0	0	(7,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,078)	0	0	0	0	0	0	0	0	0	0	(1,078)	36
37	**TOTAL Ownership**	(1,078)	1,845	0	0	0	0	0	0	0	0	0	767	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)**	(202,765)	1,845	0	0	0	0	0	0	0	0	0	(200,920)	45

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	Carlinville Estates	Carlinville	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 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	$	TwoCan, Inc	100.00%	$ 1,741	$ 1,741	1
2	V	30	Depreciation		RLG Real Estate, LLC	100.00%	3,562	3,562	2
3	V	32	Interest		RLG Real Estate, LLC	100.00%	4,342	4,342	3
4	V	34	Rent	7,800	RLG Real Estate, LLC	100.00%		(7,800)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 7,800			$ 9,645	$ * 1,845	14

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Richard L. Grader	President	Administration	100.00	See attached	10	20.00	Wages	$ 22,802	17,1	1
2	Daniel P. Caulkins				See attached	10	20.00	Wages	4,472	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	$ 27,274		13

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

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 [ ] 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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	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	$ 722,800	$ 662,074	9/16/19	3.6500	$ 13,070	1
2	Related Parties	X		Interest Income						0.2200	(692)	2
3												3
4												4
5												5
	Working Capital											
6	Hickory Point Bank		X	Working Capital		9/16/16	182,000	165,849		3.5000	5,016	6
7	Hickory Point Bank		X	Interest Income							(13)	7
8												8
9	TOTAL Facility Related						$ 904,800	$ 827,923			$ 17,381	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 904,800	$ 827,923			$ 17,381	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 Patterson House # 0037341 Report Period Beginning: 10/01/16 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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2016 report.	$	6,215	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.)	$	9,606	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,391	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	6,357	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	9,748	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2012	6,203	8
	2013	6,445	9
	2014	6,475	10
	2015	6,675	11
	2016	6,786	12

	FOR BHF USE ONLY		
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

Line 2, R/E taxes paid: Patterson House bill $6,786 + $2,820 Central office bill = $9,606

Line 4, R/E tax accrual: 9/12 Patterson House bill $5,089 + Central Office bill $1,268 = $6,357

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 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 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)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	08-08-01-311-002	NE/1/4&2NW1/4BLK 7 Kellars	$ 6,786.00	$ 6,786.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,786.00	$ 6,786.00

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 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.

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 [ ] 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	15,000	1991	$ 20,550	1
2					2
3	TOTALS	15,000		$ 20,550	3

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1991	1991	$ 230,924	$ 5,773	39	$ 5,773	$	$ 151,105	4
5											5
6											6
7											7
8	Central Office		2005		132,849		39	3,562	3,562	13,531	8
	Improvement Type**										
9	Driveways			1991	16,799		10			16,799	9
10	Landscaping			1991	4,593		10			4,593	10
11	New floor/tile			1998	2,759		10			2,759	11
12	New carpet			2000	2,810		10			2,810	12
13	New roof			2007	11,410	570	20	570		5,800	13
14	Bathroom/kitchen remodeling			2007	3,223	215	15	215		2,095	14
15	(2) exit doors			2008	3,866	258	15	258		2,276	15
16	(3) outswing entry doors			2009	3,025	202	15	202		1,597	16
17	(2) Furnaces			2013	7,991	205	39	205		888	17
18	Bathroom remodel - tub/shower surround, faucet, 2 assist bars			2016	6,598	169	39	169		169	18
19	Bathroom remodel, 2 mens' restrooms, doors, tile, paint, shower stalls, toil			2017	14,485	124	39	124		124	19
20	Bathroom remodel, 2 mens' restrooms, drywall, grout, backsplash			2017	1,488	13	39	13		13	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	17	20	17		142	31
32	New roof			2012	3,133	125	39	125		606	32
33	Permanent Landscaping			2015	1,204	188	10	188		391	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

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)		$ 447,373	$ 7,859		$ 11,421	$ 3,562	$ 205,698	70

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	$ 139,528	$ 3,560	$ 3,560	$		$ 124,022	71
72	Current Year Purchases	5,882	262	262			262	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 145,410	$ 3,822	$ 3,822	$		$ 124,284	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	2017 Chevy Van	2017	$ 33,561	$	$	$	5	$	76
77										77
78										78
79										79
80	TOTALS			$ 33,561	$	$	$		$	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)	$ 646,894	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,681	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,243	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 329,982	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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

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.	/2018	$
13.	/2019	$
14.	/2020	$

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.

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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.

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,541	$ 56,193	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	104,757	589,504	3
4	Supply Inventory (priced at cost)	1,342	5,566	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,592	36,893	7
8	Accounts Receivable (owners or related parties)	671,999	2,584,610	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 802,231	$ 3,272,766	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	307,160	307,160	14
15	Leasehold Improvements, at Historical Cost	7,363	303,551	15
16	Equipment, at Historical Cost	178,971	660,871	16
17	Accumulated Depreciation (book methods)	(316,451)	(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)**	$ 197,593	$ 406,378	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 999,824	$ 3,679,144	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 24,830	$ 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	13,935	61,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	784	3,003	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,357	39,545	32
33	Accrued Interest Payable	940	3,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(841,151)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (794,305)	$ 203,127	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		32,675	39
40	Mortgage Payable	827,922	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)**	$ 827,922	$ 3,216,989	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 33,617	$ 3,420,116	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 966,207	$ 259,029	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 999,824	$ 3,679,145	48

*(See instructions.)

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 978,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 978,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	34,976	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)**	$ (12,017)	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)**	$ 966,207	24 *

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 660,123	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 660,123	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	503	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 503	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	199,860	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 199,860	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 860,486	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	155,525	31
32	Health Care	435,787	32
33	General Administration	156,673	33
	B. Capital Expense		
34	Ownership	41,606	34
	C. Ancillary Expense		
35	Special Cost Centers	553	35
36	Provider Participation Fee	35,366	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 825,510	40
41	**Income before Income Taxes (line 30 minus line 40)****	34,976	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 34,976	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 660,123	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)	$ 660,123	49

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

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

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/01/16 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	791	892	11,418	12.80	9
10	Activity Assistants	1,882	1,882	17,445	9.27	10
11	Social Service Workers	2,369	2,369	44,015	18.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,963	2,077	25,547	12.30	14
15	Cook Helpers/Assistants	688	669	5,676	8.48	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,888	4,007	39,291	9.81	18
19	Laundry					19
20	Administrator	508	546	6,760	12.38	20
21	Assistant Administrator					21
22	Other Administrative	499	541	27,274	50.41	22
23	Office Manager					23
24	Clerical	510	541	11,245	20.79	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)	12,368	12,613	134,206	10.64	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,466	26,137	$ 322,877 *	$ 12.35	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	37	$ 1,806	1,3	35
36	Medical Director	$350/mo	7,142	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	332	12,462	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,136	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	13	1,030	12	45
46	Other(specify)				46
47	Psychology Consultant	14	1,086	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	421	$ 24,662		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Patterson House # 0037341 Report Period Beginning: 10/01/16 Ending: 9/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Grader	Administrative	100	$ 22,802
Daniel Caulkins	Administrative		4,472
Jennifer Haseley	Office Assistant		11,245
Nicki Palmer	Administrative		6,760
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 45,279

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, Postlewait et al	Legal	$ 1,094
Sikich		11,041
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 12,135

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,178
Unemployment Compensation Insurance	3,477
FICA Taxes	24,519
Employee Health Insurance	14,382
Employee Meals	1,398
Illinois Municipal Retirement Fund (IMRF)*	
Employee Medical Expenses	2,710
Other Employee Expenses	4,140
Education	51
TOTAL (agree to Schedule V, line 22, col.8)	$ 57,855

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	222
Health Care Worker Background Check	
(Indicate # of checks performed 3)	
Patient Background Checks 0	
Dues and Subscriptions	845
Fees and licenses	286
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,353

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number **Patterson House** **#** **0037341** **Report Period Beginning:** **10/01/16** **Ending:** **9/30/17**

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. $ **35,366**
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. $ **553**
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?
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) 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.
Carlinville Estates 10/1/16 - 9/30/17
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 TwoCan, Inc. on its mortgage was:

Hickory Point Bank: 5,891

The interest is allocated as follows:

Carlinville Estates	1,607
Emerald Estates	937
Marigold Estates	1,607
Patterson House	1,740
	5,891

Patterson House, Inc. 10/1/16 - 9/30/17
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability 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:

Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House

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

Hickory Point Bank	14,696

The interest is allocated as follows:

Carlinville Estates	4,008
Emerald Estates	2,338
Marigold Estates	4,008
Patterson House	4,342
	14,696

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

10/1/16 - 9/30/17

Page 7, Part VII, C

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

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

** 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. 10/1/16 - 9/30/17
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

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	Operations of the facilities	Reviewing vendor invoices
Approving vendors	Supervising employees	Paying invoices
Reviewing accounts receivable	Dealing with consultants	Dealing with local day program agencies
Following up on billing discrepancies	Buying supplies	Attending employee meetings
Managing cash flow	Inspecting the facilities	Recruiting employees
Negotiating with the bank	Locating residents	Dealing with employee complaints
Bookkeeping	Dealing with residents' families	
All financial management functions	Dealing with government agencies	

The above duties are not all encompassing.

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, 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:
Carlinvile - 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
	550,494	132,118	77,070	132,118	143,128	66,058	

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc. 10/1/16 - 9/30/17

Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

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

Patterson House (#0037341) 10/1/16 - 9/30/17

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	503

Line 28, Other Revenue

Social Security	-
Earning Credits	2,770
Residents' travel reimbursement	553
Gain on asset disposal	130
Miscellaneous income	7
Workshop	196,400
	199,860

**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

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