

		FOR BHF USE					

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**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

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><b>I. IDPH License ID Number:</b> <u>0039362</u></p> <p><b>Facility Name:</b> <u>Carlinville Estates</u></p> <p><b>Address:</b> <u>1221 South Plum Street</u> <u>Carlinville</u> <u>62626</u>          Number City Zip Code</p> <p><b>County:</b> <u>Macoupin</u></p> <p><b>Telephone Number:</b> <u>217-854-9443</u> Fax # <u>217-854-9324</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/26/94</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>David W. White</u> <b>Telephone Number:</b> <u>217-423-6000</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/17</u> to <u>9/30/18</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 style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Richard L. Grader</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>David W. White, C.P.A.</u> <u>Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Sikich LLP</u> <u>132 S. Water St., Ste 300, Decatur IL, 62523</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>217-423-6000</u> Fax # <u>217-423-6100</u></td> <td></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Richard L. Grader</u>			(Title) <u>President</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(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>	
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Facility Name & ID Number Carlinville Estates

# 0039362 Report Period Beginning: 10/1/17 Ending: 9/30/18

**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	5,616			5,616	13
14	TOTALS	5,616			5,616	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.16%**

**D. How many bed reserve days during this year were paid by the Department?**  
4 (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 12/1/93

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date \_\_\_\_\_ 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: 12/31/18 Fiscal Year: 9/30/18

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

Facility Name & ID Number Carlinville Estates # 0039362 Report Period Beginning: 10/1/17 Ending: 9/30/18

**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
	<b>A. General Services</b>										
1	Dietary	39,572	1,819	1,359	42,750		42,750		42,750		1
2	Food Purchase		31,560		31,560		31,560		31,560		2
3	Housekeeping	28,294	3,989		32,283		32,283		32,283		3
4	Laundry		3,966		3,966		3,966		3,966		4
5	Heat and Other Utilities			16,468	16,468		16,468		16,468		5
6	Maintenance		1,478	10,125	11,603		11,603		11,603		6
7	Other (specify):* <b>Garbage Service</b>			760	760		760		760		7
8	<b>TOTAL General Services</b>	67,866	42,812	28,712	139,390		139,390		139,390		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,467	1,467		1,467		1,467		9
10	Nursing and Medical Records	155,684	8,742	20,483	184,909		184,909		184,909		10
10a	Therapy			2,566	2,566		2,566		2,566		10a
11	Activities	24,334	1,929		26,263		26,263		26,263		11
12	Social Services	38,970		200	39,170		39,170		39,170		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Workshop</b>			183,913	183,913		183,913	(183,913)			15
16	<b>TOTAL Health Care and Programs</b>	218,988	10,671	208,629	438,288		438,288	(183,913)	254,375		16
	<b>C. General Administration</b>										
17	Administrative	44,926		1	44,927		44,927	(1)	44,926		17
18	Directors Fees										18
19	Professional Services			10,068	10,068		10,068		10,068		19
20	Dues, Fees, Subscriptions & Promotions			2,964	2,964		2,964	(918)	2,046		20
21	Clerical & General Office Expenses		6,960	4,907	11,867		11,867		11,867		21
22	Employee Benefits & Payroll Taxes			54,624	54,624		54,624	(611)	54,013		22
23	Inservice Training & Education			835	835		835		835		23
24	Travel and Seminar			78	78		78		78		24
25	Other Admin. Staff Transportation			20,652	20,652	(14,744)	5,908		5,908		25
26	Insurance-Prop.Liab.Malpractice			8,102	8,102		8,102		8,102		26
27	Other (specify):* <b>Contributions</b>			596	596		596	(596)			27
28	<b>TOTAL General Administration</b>	44,926	6,960	102,827	154,713	(14,744)	139,969	(2,126)	137,843		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	331,780	60,443	340,168	732,391	(14,744)	717,647	(186,039)	531,608		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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			8,485	8,485		8,485	10,469	18,954		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			11,472	11,472		11,472	4,953	16,425		32
33	Real Estate Taxes			9,614	9,614		9,614		9,614		33
34	Rent-Facility & Grounds			36,696	36,696		36,696	(36,696)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>State repl tax</b>			816	816		816	(816)			36
37	<b>TOTAL Ownership</b>			67,083	67,083		67,083	(22,090)	44,993		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation					14,744	14,744		14,744		38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,538	38,538		38,538		38,538		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			38,538	38,538	14,744	53,282		53,282		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	331,780	60,443	445,789	838,012		838,012	(208,129)	629,883		45

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

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(183,913)	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	(789)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1)	17		18
19	Entertainment	(611)	22		19
20	Contributions	(596)	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	(129)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(816)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (186,855)		\$	30

BHF USE ONLY							
48		49		50		51	

**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	2	
		Amount	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)	(21,274)	30,32,34	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (21,274)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (208,129)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.	X		\$ 14,744	25
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 14,744	47

Carlinville Estates

ID# 0039362

Report Period Beginning: 10/1/17

Ending: 9/30/18

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
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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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlinville Estates# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

## 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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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):*	(183,913)	0	0	0	0	0	0	0	0	0	0	(183,913)	15
16	<b>TOTAL Health Care and Programs</b>	(183,913)	0	0	0	0	0	0	0	0	0	0	(183,913)	16
	<b>C. General Administration</b>													
17	Administrative	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	(918)	0	0	0	0	0	0	0	0	0	0	(918)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(611)	0	0	0	0	0	0	0	0	0	0	(611)	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):*	(596)	0	0	0	0	0	0	0	0	0	0	(596)	27
28	<b>TOTAL General Administration</b>	(2,126)	0	0	0	0	0	0	0	0	0	0	(2,126)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(186,039)	0	0	0	0	0	0	0	0	0	0	(186,039)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

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	10,469	0	0	0	0	0	0	0	0	0	10,469	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	4,953	0	0	0	0	0	0	0	0	0	4,953	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,696)	0	0	0	0	0	0	0	0	0	(36,696)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(816)	0	0	0	0	0	0	0	0	0	0	(816)	36
37	<b>TOTAL Ownership</b>	<b>(816)</b>	<b>(21,274)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(22,090)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(186,855)</b>	<b>(21,274)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(208,129)</b>	<b>45</b>



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
<u>Richard L. Grader</u>	<u>100</u>	<u>Carlinville Estates</u>	<u>Carlinville</u>	<u>TwoCan, Inc</u>	<u>Decatur</u>	<u>Landlord</u>
		<u>Emerald Estates</u>	<u>Canton</u>	<u>RLG Real Estate, LLC</u>	<u>Decatur</u>	<u>Landlord</u>
		<u>Marigold Estates</u>	<u>Pekin</u>			
		<u>Patterson House</u>	<u>Sullivan</u>			

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	<u>30 Depreciation</u>	\$	<u>TwoCan, Inc</u>	<u>100.00%</u>	\$ <u>6,908</u>	\$ <u>6,908</u>	1
2	V	<u>32 Interest</u>		<u>TwoCan, Inc</u>	<u>100.00%</u>	<u>1,333</u>	<u>1,333</u>	2
3	V	<u>34 Rent</u>	<u>29,496</u>	<u>TwoCan, Inc</u>	<u>100.00%</u>		<u>(29,496)</u>	3
4	V	<u>30 Depreciation</u>		<u>RLG Real Estate, LLC</u>	<u>100.00%</u>	<u>3,561</u>	<u>3,561</u>	4
5	V	<u>32 Interest</u>		<u>RLG Real Estate, LLC</u>	<u>100.00%</u>	<u>3,620</u>	<u>3,620</u>	5
6	V	<u>34 Rent</u>	<u>7,200</u>	<u>RLG Real Estate, LLC</u>	<u>100.00%</u>		<u>(7,200)</u>	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>36,696</u>			\$ <u>15,422</u>	\$ * <u>(21,274)</u>	14

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

Facility Name & ID Number

Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

**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 &amp; ID Number

Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

## 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	\$ 20,665	17,1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,665		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 Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Central Office - Patterson House

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

Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Hickory Point Bank		X	Mortgage - refinanced		9/16/16	\$ 667,200	\$ 552,777	9/16/19	3.6500	\$ 12,059	1								
2	Related Parties	X		Interest Income						0.2200	(711)	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Hickory Point Bank		X	Working Capital		9/16/16	168,000	150,954		5.2500	5,568	6								
7	Hickory Point Bank		X	Interest Income							(23)	7								
8	State of Illinois		X	Interest Income							(468)	8								
9	<b>TOTAL Facility Related</b>						\$ 835,200	\$ 703,731			\$ 16,425	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 835,200	\$ 703,731			\$ 16,425	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.)

**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 2017 report.	\$	<b>8,496</b>	<b>1</b>
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.)	\$	<b>9,662</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>1,166</b>	<b>3</b>
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>8,448</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>9,614</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<b>6,579</b>	<b>8</b>
	2014	<b>6,697</b>	<b>9</b>
	2015	<b>6,756</b>	<b>10</b>
	2016	<b>7,123</b>	<b>11</b>
	2017	<b>7,111</b>	<b>12</b>

**Line 2, R/E taxes paid: Carlinville Estates bill \$7,111 + \$2,551 Central Office bill = \$9,662**

**Line 4, R/E tax accrual: 9/12 Carlinville Estates bill \$5,333 + Central Office bill \$3,115 = \$8,448**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Carlinville Estates COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0039362

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 2017 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 2017.

(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>12-001-990-00</u>	<u>Lots 1-12 BLK 21 Hoxsey &amp; Edwards</u>	\$ <u>7,111.00</u>	\$ <u>7,111.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>7,111.00</u></u>	\$ <u><u>7,111.00</u></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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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 Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

**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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>102,379</u>	<u>1993</u>	<u>\$ 18,747</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>102,379</b>		<b>\$ 18,747</b>	<b>3</b>



**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	\$ 274,054	\$	39	\$ 6,908	\$ 6,908	\$ 170,736	4
5										5
6										6
7										7
8	Central Office	2005		132,849		39	3,561	3,561	17,084	8
	<b>Improvement Type**</b>									
9	Remodel interior		1996	5,000		20			5,000	9
10	Bathroom remodel		1999	2,224	111	20	111		2,011	10
11	Bathroom remodel		2000	4,773	239	20	239		4,693	11
12	Countertop		2001	749	19	39	19		323	12
13	New floor		2002	2,300		7			2,300	13
14	New roof		2002	10,500	525	20	525		8,488	14
15	Trane furnaces, Qty 2		2005	4,700		7			4,700	15
16	Carpet		2005	8,349		7			8,349	16
17	Vinyl floor		2008	1,195		5			1,195	17
18	Bathroom remodel - seated shower, handheld shower, toilet		2016	5,902	151	39	151		404	18
19	Bathroom remodel - new tub and toilets		2016	5,792	149	39	149		334	19
20	Carpet, resident rooms		2017	8,539	1,220	7	1,220		1,931	20
21	Bathroom remodel - new sinks and showers, 2 mens' restroom:		2017	12,722	326	39	326		435	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	226	22	20	22		146	31
32	New roof		2012	3,139	126	39	126		675	32
33	Permanent landscaping		2015	1,204	173	10	173		534	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)	\$ 484,217	\$ 3,061		\$ 13,530	\$ 10,469	\$ 229,338	70

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

Facility Name & ID Number Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

**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	\$ 90,294	\$ 1,838	\$ 1,838	\$		\$ 85,221	71
72	Current Year Purchases	3,700	176	176			176	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 93,994	\$ 2,014	\$ 2,014	\$		\$ 85,397	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	\$ 34,095	\$	\$	\$	5	\$ 34,095	76
77	Facility	Chevy G30 Van	2018	25,579	3,410	3,410		5	3,410	77
78										78
79										79
80	<b>TOTALS</b>			\$ 59,674	\$ 3,410	\$ 3,410	\$		\$ 37,505	80

**E. Summary of Care-Related Assets**

	1	2	
	Reference	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)	\$ 656,632 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,485 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,954 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,469 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 352,240 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	<b>TOTALS</b>	\$	\$	\$	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 Carlinville Estates

# 0039362

Report Period Beginning: 10/1/17

Ending: 9/30/18

**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	<b>TOTAL</b>				\$			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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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	<b>TOTAL</b>		\$	\$	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	<b>TOTAL</b>			\$		\$	\$		\$	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 **Carlinville Estates**

# **0039362**

Report Period Beginning: **10/1/17**

Ending:

**9/30/18**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **9/30/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 534	\$ 2,458	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	101,501	567,205	3
4	Supply Inventory (priced at cost )	1,679	6,614	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,523	31,348	7
8	Accounts Receivable (owners or related parties)	577,016	2,404,232	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 688,253	\$ 3,011,857	10
	<b>B. Long-Term Assets</b>			
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	77,299	310,153	15
16	Equipment, at Historical Cost	153,667	693,207	16
17	Accumulated Depreciation (book methods)	(164,421)	(938,190)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 66,545	\$ 392,880	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 754,798	\$ 3,404,737	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 29,049	\$ 121,038	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,292	65,959	30
31	Accrued Taxes Payable (excluding real estate taxes)	476	1,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,448	39,016	32
33	Accrued Interest Payable	785	3,269	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Intercompany</u>	(75,235)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ (23,185)	\$ 231,266	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	23,502	48,437	39
40	Mortgage Payable	703,730	2,932,210	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 727,232	\$ 2,980,647	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 704,047	\$ 3,211,913	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 50,751	\$ 192,824	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 754,798	\$ 3,404,737	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (6,991)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (6,991)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	95,206	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(37,464)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 57,742	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 50,751	<b>24</b> *

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



Facility Name & ID Number Carlinville Estates# 0039362Report Period Beginning: 10/1/17Ending: 9/30/18

**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**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 650,613	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 650,613	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	78,787	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 78,787	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached schedule</u>	203,818	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 203,818	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 933,218	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	139,390	31
32	Health Care	438,288	32
33	General Administration	139,969	33
<b>B. Capital Expense</b>			
34	Ownership	67,083	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	14,744	35
36	Provider Participation Fee	38,538	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 838,012	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	95,206	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 95,206	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 564,179	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security</u>	86,434	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 650,613	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 Carlinville Estates

# 0039362

Report Period Beginning:

10/1/17

Ending:

9/30/18

**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	312	329	3,468	10.54	9
10	Activity Assistants	1,983	2,000	20,866	10.43	10
11	Social Service Workers	2,080	2,080	38,970	18.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,102	2,198	28,105	12.79	14
15	Cook Helpers/Assistants	1,225	1,321	11,467	8.68	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,008	3,008	28,294	9.41	18
19	Laundry					19
20	Administrator	463	510	12,888	25.27	20
21	Assistant Administrator					21
22	Other Administrative	470	509	20,665	40.60	22
23	Office Manager					23
24	Clerical	457	499	11,373	22.79	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)	14,246	14,532	155,684	10.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,346	26,986	\$ 331,780 *	\$ 12.29	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	\$ 1,359	1,3	35
36	Medical Director	\$300/mo	1,467	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	566	19,114	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	9	450		40
41	Occupational Therapy Consultant	2	113	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	11	660	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	2	199	12	45
46	Other(specify)				46
47	Psychiatric Consultant	3	240	10a,3	47
48	Psychologist Consultant	15	1,229	10a,3	48
49	TOTAL (lines 35 - 48)	636	\$ 24,831		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	\$ 20,665	Workers' Compensation Insurance	\$ 7,243	IDPH License Fee	\$		
Jennifer Haseley	Office Assistant		11,237	Unemployment Compensation Insurance	3,095	Advertising: Employee Recruitment	405		
Joan Navratil	Office Assistant		136	FICA Taxes	24,561	Health Care Worker Background Check			
Nicki Palmer	Administrative		12,287	Employee Health Insurance	8,404	(Indicate # of checks performed <u>10</u> )			
Lora Dillman	Administrative		601	Employee Meals	4,315	Patient Background Checks	<u>0</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	394		
				Employee Medical Expense	1,081	Fees and Licenses	1,247		
				Other Employee Expense	5,308				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 44,926	TOTAL (agree to Schedule V, line 22, col.8)		\$ 54,007	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,046
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$
C. Professional Services									
Vendor/Payee	Type		Amount						
Featherstun, Postlewait et al	Legal		\$ 277						
Verticchio & Verticchio	Legal		940						
Sikich	CPA		8,851						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 10,068						

\* 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. \$ 38,538  
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 benefit 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. \$ 14,744
  - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
  - d. Have vehicle usage logs been maintained? Yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees

Patterson House, Inc.		
Carlenville Estates	(#0039362)	10/1/17 - 9/30/18
Emerald Estates		
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:	4,889
---------------------	-------

The interest is allocated as follows:

Carlenville Estates	1,333
Emerald Estates	778
Marigold Estates	1,333
Patterson House	<u>1,445</u>
	<u><u>4,889</u></u>

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

(# 0039362)

10/1/17 - 9/30/18

**Page 6, Part VII, B**

The Central Office building and land are owned by a related limited liability corporation, Richard Grader Real Estate LLC, which 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	<u>13,273</u>
--------------------	---------------

The interest is allocated as follows:

Carlinville Estates	3,620
Emerald Estates	2,112
Marigold Estates	3,620
Patterson House	<u>3,921</u>
	<u><u>13,273</u></u>

Patterson House, Inc.  
Carlinville Estates (# 0039362)  
Emerald Estates  
Marigold Estates  
Patterson House

10/1/17 - 9/30/18

Page 7, Part VII, C

Owners' Compensation  
10/1/17 - 9/30/18

	<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	86,104	20,665	12,055	20,665	22,387	4,305	6,027

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

(# 0039362)

10/1/17 - 9/30/18

Owners' Compensation  
10/1/17 - 9/30/18

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.



Allocation of Central Office Costs - Fiscal Year Ended September 30, 2018

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	6	1	1	1	2	1	1
Housekeeping Supplies	477	115	67	114	124	57	3
Utilities	12,397	2,975	1,736	2,975	3,223	1,488	5
Maintenance	9,177	2,203	1,285	2,202	2,386	1,101	6
Nondepreciable equipment (consumable items)	149	36	21	36	38	18	7
Nursing Consultant fees	2,681	643	375	644	697	322	10
Administrative Salaries	161,252	38,700	22,575	38,701	41,926	19,350	17
Penalties	5	1	1	1	1	1	17
Professional Services	38,035	9,128	5,325	9,129	9,889	4,564	19
Dues, Fees and Subscriptions	5,650	1,356	791	1,356	1,469	678	20
Contributions	2,485	596	348	597	646	298	20
Advertising	571	138	80	137	148	68	20
Office Supplies	8,092	1,942	1,133	1,942	2,104	971	21
Other Office Expense	590	141	83	142	153	71	21
Postage	1,997	479	280	479	519	240	21
Telephone	9,414	2,259	1,318	2,259	2,448	1,130	21
Payroll Taxes	13,168	3,160	1,844	3,160	3,424	1,580	22
Group Health Insurance	61,565	14,776	8,619	14,776	16,006	7,388	22
Workers Comp Insurance	30,180	7,243	4,225	7,243	7,847	3,622	22
Business Meals	16,735	4,016	2,343	4,017	4,351	2,008	22
Entertainment	2,547	611	357	611	662	306	22
Other Employee Benefits	18,910	4,538	2,648	4,538	4,917	2,269	22
Inservice Training & Education	798	192	111	192	207	96	23
Other Admin/Staff Transportation	52,035	12,488	7,285	12,489	13,529	6,244	25
Insurance	33,602	8,065	4,704	8,064	8,737	4,032	26
Depreciation	3,512	843	492	843	913	421	30
Interest Expense	46,315	11,116	6,484	11,116	12,041	5,558	32
Real Estate Taxes	10,471	2,513	1,466	2,513	2,722	1,257	33
Lease - Central Office	30,000	7,200	4,200	7,200	7,800	3,600	34
IL replacement tax	3,400	816	476	816	884	408	36
	<u>576,216</u>	<u>138,289</u>	<u>80,672</u>	<u>138,292</u>	<u>149,811</u>	<u>69,146</u>	

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Patterson House, Inc.  
Carlinville Estates (# 0039362)  
Emerald Estates  
Marigold Estates  
Patterson House

10/1/17 - 9/30/18

Page 9, Part IX

Mortgage

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

Balance @ 9/30/18 2,303,236

Carlinville Estates	552,777
Emerald Estates	322,453
Marigold Estates	552,777
Patterson House	598,841

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

Carlinville Estates (#0039362)

10/1/17 - 9/31/18

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	<u>78,787</u>
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Line 28, Other Revenue

Social Security	-
Earning Credits	5,161
Residents' travel reimbursement	14,744
Room rental income	-
Workshop	<u>183,913</u>
	203,818

\*\*Facility fiscal year end is 9/30/18, tax year end is 12/31/18.  
Taxable income will not agree.

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

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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

Carlinville Estates (#0039362)

10/1/17 - 9/30/18

Page 3, Part V

Line 25, Other Admin Staff Transportation

Vehicle expense	1,344
Vehicle fuel	4,220
Vehicle lease	3,630
Mileage	11,458
Medically necessary transportation	(14,744)
	<u>5,908</u>

\*\*Facility fiscal year end is 9/30/18, tax year end is 12/31/18.  
Taxable income will not agree.

SEE INDEPENDENT ACCOUNTANT'S COMPILATION REPORT