FOR BHF USE

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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.

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

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:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David W. White Telephone Number: 217-423-6000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/17 to 9/30/18 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: 10/1/17 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,825			4,825	13
14	TOTALS	4,825			4,825	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.62%

D. How many bed reserve days during this year were paid by the Department?
58 (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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/15/91

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

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 Patterson House # 0037341 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	33,179	1,273	1,486	35,938		35,938		35,938			1
2	Food Purchase		37,283		37,283		37,283		37,283			2
3	Housekeeping	41,612	2,626		44,238		44,238		44,238			3
4	Laundry		798		798		798		798			4
5	Heat and Other Utilities			22,334	22,334		22,334		22,334			5
6	Maintenance		3,335	13,332	16,667		16,667		16,667			6
7	Other (specify):* Garbage			1,700	1,700		1,700		1,700			7
8	TOTAL General Services	74,791	45,315	38,852	158,958		158,958		158,958			8
	B. Health Care and Programs											
9	Medical Director			1,400	1,400		1,400		1,400			9
10	Nursing and Medical Records	125,545	5,529	22,755	153,829		153,829		153,829			10
10a	Therapy			1,855	1,855		1,855		1,855			10a
11	Activities	25,648	1,673		27,321		27,321		27,321			11
12	Social Services	43,153		167	43,320		43,320		43,320			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			143,016	143,016		143,016	(143,016)				15
16	TOTAL Health Care and Programs	194,346	7,202	169,193	370,741		370,741	(143,016)	227,725			16
	C. General Administration											
17	Administrative	48,670		1	48,671		48,671	(1)	48,670			17
18	Directors Fees											18
19	Professional Services			9,889	9,889		9,889		9,889			19
20	Dues, Fees, Subscriptions & Promotions			2,982	2,982		2,982	(886)	2,096			20
21	Clerical & General Office Expenses		7,875	5,463	13,338		13,338		13,338			21
22	Employee Benefits & Payroll Taxes			56,282	56,282		56,282	(662)	55,620			22
23	Inservice Training & Education			958	958		958		958			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			24,720	24,720	(1,570)	23,150		23,150			25
26	Insurance-Prop.Liab.Malpractice			8,736	8,736		8,736		8,736			26
27	Other (specify):* Contributions			646	646		646	(646)				27
28	TOTAL General Administration	48,670	7,875	109,677	166,222	(1,570)	164,652	(2,195)	162,457			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	317,807	60,392	317,722	695,921	(1,570)	694,351	(145,211)	549,140			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Patterson House #0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			19,243	19,243		19,243	3,561	22,804			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,042	12,042		12,042	5,366	17,408			32
33	Real Estate Taxes			8,962	8,962		8,962		8,962			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			884	884		884	(884)				36
37	**TOTAL Ownership**			48,931	48,931		48,931	243	49,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,570	1,570		1,570			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,703	39,703		39,703		39,703			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			39,703	39,703	1,570	41,273		41,273			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	317,807	60,392	406,356	784,555		784,555	(144,968)	639,587			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: 10/1/17 Ending: 9/30/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(143,016)	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	(855)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1)	17		18
19	Entertainment	(662)	22		19
20	Contributions	(646)	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	(31)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(884)	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)**	$ (146,095)		$	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)	1,128	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,128		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (144,967)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 1,570	25	38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,570		47

Patterson House

ID# 0037341

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
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(143,016)	0	0	0	0	0	0	0	0	0	0	(143,016)	15
16	**TOTAL Health Care and Programs**	(143,016)	0	0	0	0	0	0	0	0	0	0	(143,016)	16
	C. General Administration													
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	(886)	0	0	0	0	0	0	0	0	0	0	(886)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(662)	0	0	0	0	0	0	0	0	0	0	(662)	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):*	(646)	0	0	0	0	0	0	0	0	0	0	(646)	27
28	**TOTAL General Administration**	(2,195)	0	0	0	0	0	0	0	0	0	0	(2,195)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(145,211)	0	0	0	0	0	0	0	0	0	0	(145,211)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Patterson House # 0037341 **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	3,561	0	0	0	0	0	0	0	0	0	3,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	5,366	0	0	0	0	0	0	0	0	0	5,366	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):*	(884)	0	0	0	0	0	0	0	0	0	0	(884)	36
37	**TOTAL Ownership**	(884)	1,127	0	0	0	0	0	0	0	0	0	243	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)**	(146,095)	1,127	0	0	0	0	0	0	0	0	0	(144,968)	45

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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 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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	$	TwoCan, Inc	100.00%	$ 1,444	$ 1,444	1
2	V	30	Depreciation		RLG Real Estate, LLC	100.00%	3,561	3,561	2
3	V	32	Interest		RLG Real Estate, LLC	100.00%	3,922	3,922	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			$ 8,927	$ * 1,127	14

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 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 & ID Number Patterson House # 0037341 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Richard L. Grader	President	Administration	100.00	See attached	10	20.00	Wages	$ 22,387	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	$ 22,387		13

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Central Office - Patterson House
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: 10/1/17 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				
	A. Directly Facility Related											
	Long-Term											
1	Hickory Point Bank		x	Mortgage - refinanced		9/16/16	$ 722,800	$ 598,842	9/16/19	3.6500	$ 12,171	1
2	Related Parties	x		Interest Income							(770)	2
3												3
4												4
5												5
	Working Capital											
6	Hickory Point Bank		x	Working Capital		9/16/16	182,000	163,533		5.2500	6,032	6
7	Hickory Point Bank		x	Interest Income							(25)	7
8												8
9	TOTAL Facility Related						$ 904,800	$ 762,375			$ 17,408	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	$ 762,375			$ 17,408	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: 10/1/17 Ending: 9/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 6,357	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.)		$ 9,238	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,881	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 6,081	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,962	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	6,445	8
	2014	6,475	9
	2015	6,675	10
	2016	6,786	11
	2017	6,474	12

Line 2, R/E taxes paid: Patterson House bill $6,474 +$2,764 Central Office bill = $9,238

Line 4, R/E tax accrual: 9/12 Patterson House bill $4,855 + Central Office bill $1,226 = $6,081

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2017 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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-01-311-002	307 E Jefferson St NE1/4 & E1/2	$ 6,473.88	$ 6,473.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,473.88	$ 6,473.88

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 Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	$ 230,924	$ 5,772	39	$ 5,772	$	$ 156,878	4
5											5
6											6
7											7
8	Central Office		2005		132,849		39	3,561	3,561	17,083	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		6,371	13
14	Bathroom/kitchen remodeling			2007	3,223	215	15	215		2,310	14
15	(2) exit doors			2008	3,866	257	15	257		2,534	15
16	(3) outswing entry doors			2009	3,025	201	15	201		1,798	16
17	(2) Furnaces			2013	7,991	205	39	205		1,093	17
18	Bathroom remodel - tub/shower surround, faucet, 2 assist bars			2016	6,598	169	39	169		338	18
19	Bathroom remodel, 2 mens' restrooms, doors, tile, paint, shower stalls, toil			2017	14,485	371	39	371		495	19
20	Bathroom remodel, 2 mens' restrooms, drywall, grout, backsplash			2017	1,488	38	39	38		51	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	16	20	16		159	31
32	New roof			2012	3,133	125	39	125		731	32
33	Permanent Landscaping			2015	1,204	188	10	188		579	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	$ 8,127		$ 11,688	$ 3,561	$ 217,381	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: 10/1/17 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	$ 145,410	$ 4,113	$ 4,113	$		$ 128,400	71
72	Current Year Purchases	3,057	291	291			291	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 148,467	$ 4,404	$ 4,404	$		$ 128,691	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	$ 6,712	$ 6,712	$	5	$ 26,849	76
77										77
78										78
79										79
80	TOTALS			$ 33,561	$ 6,712	$ 6,712	$		$ 26,849	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 649,951	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,243	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,804	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,561	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 372,921	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 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	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.	/2019	$
13.	/2020	$
14.	/2021	$

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: 10/1/17 Ending: 9/30/18

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.)

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

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

STATE OF ILLINOIS

Facility Name & ID Number Patterson House # 0037341 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 570	$ 2,458	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	117,194	567,205	3
4	Supply Inventory (priced at cost)	621	6,614	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,151	31,348	7
8	Accounts Receivable (owners or related parties)	625,100	2,404,232	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 751,636	$ 3,011,857	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	310,153	15
16	Equipment, at Historical Cost	182,027	693,207	16
17	Accumulated Depreciation (book methods)	(335,699)	(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	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 181,401	$ 392,880	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 933,037	$ 3,404,737	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,470	$ 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	13,339	65,959	30
31	Accrued Taxes Payable (excluding real estate taxes)	516	1,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,081	39,016	32
33	Accrued Interest Payable	850	3,269	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(810,714)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (758,458)	$ 231,266	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,293	48,437	39
40	Mortgage Payable	762,375	2,932,210	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)**	$ 783,668	$ 2,980,647	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,210	$ 3,211,913	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 907,827	$ 192,824	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 933,037	$ 3,404,737	48

*(See instructions.)

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 966,207	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 966,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,916)	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	(37,464)	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)**	$ (58,380)	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)**	$ 907,827	24 *

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 617,414	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 617,414	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	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	146,225	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 146,225	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 763,639	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	158,958	31
32	Health Care	370,741	32
33	General Administration	164,652	33
	B. Capital Expense		
34	Ownership	48,931	34
	C. Ancillary Expense		
35	Special Cost Centers	1,570	35
36	Provider Participation Fee	39,703	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 784,555	40
41	**Income before Income Taxes (line 30 minus line 40)****	(20,916)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (20,916)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 501,778	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Social Security	115,636	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 617,414	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: 10/1/17 Ending: 9/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	589	668	8,173	12.24	9
10	Activity Assistants	1,825	2,175	17,476	8.03	10
11	Social Service Workers	4,200	4,240	43,153	10.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,873	2,027	26,329	12.99	14
15	Cook Helpers/Assistants	694	848	6,850	8.08	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,896	3,994	41,611	10.42	18
19	Laundry					19
20	Administrator	501	552	13,962	25.29	20
21	Assistant Administrator					21
22	Other Administrative	510	551	22,387	40.63	22
23	Office Manager					23
24	Clerical	495	541	12,321	22.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,948	12,026	125,545	10.44	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,531	27,622	$ 317,807 *	$ 11.51	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	30	$ 1,486	1,3	35
36	Medical Director	$117/mo	1,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	642	21,653	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	10	883	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	2	167	12	45
46	Other(specify)				46
47	Psychology Consultant	13	1,072	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	697	$ 26,661		49

C. CONTRACT NURSES

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Grader	Administrative	100	$ 22,387
Jennifer Haseley	Office Assistant		12,174
Joan Navratil	Office Assistant		147
Nicki Palmer	Administrative		13,311
Lora Dillman	Administrative		651
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,670

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	$ 300
Sikich, LLP	CPA	9,589
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 9,889

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,847
Unemployment Compensation Insurance	2,948
FICA Taxes	24,836
Employee Health Insurance	9,104
Employee Meals	4,351
Illinois Municipal Retirement Fund (IMRF)*	
Employee Medical Expenses	1,342
Other Employee Expenses	5,192
TOTAL (agree to Schedule V, line 22, col.8)	$ 55,620

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	306
Health Care Worker Background Check	
(Indicate # of checks performed 4)	
Patient Background Checks 0	
Dues and Subscriptions	873
Fees and licenses	917
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,096

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/17 Ending: 9/30/18

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. $ **39,703**
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? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **1,570**
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.
Carlinville Estates 10/1/17 - 9/30/18
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:	4,889

The interest is allocated as follows:

Carlinville Estates	1,333
Emerald Estates	778
Marigold Estates	1,333
Patterson House	1,445
	4,889

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	13,273

The interest is allocated as follows:

Carlinville Estates	3,620
Emerald Estates	2,112
Marigold Estates	3,620
Patterson House	3,921
	13,273

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

10/1/17 - 9/30/18

Page 7, Part VII, C

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

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	Elin House (CILA)	Greykin House (CILA)
Richard L. Grader	86,104	20,665	12,055	20,665	22,387	4,305	6,027

Patterson House, Inc. 10/1/17 - 9/30/18
Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House (#0037341)

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	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.

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:
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	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
	576,216	138,289	80,672	138,292	149,811	69,146	

Patterson House, Inc. 10/1/17 - 9/30/18
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 @ 9/30/18	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

Patterson House (#0037341) 10/1/17 - 9/31/18

Page 19, Part XVII

Line 21, Other Medical Services

HAB Aid training reimbursement	-

Line 28, Other Revenue

Social Security	(2,976)
Earning Credits	4,614
Residents' travel reimbursement	1,570
Room rental income	-
Workshop	143,016
	146,225

**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

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

Line 25, Other Admin Staff Transportation

Vehicle expense	3,057
Vehicle fuel	4,545
Vehicle lease	3,933
Mileage	13,185
Medically necessary transportation	(1,570)
	23,150

**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