FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0039354

Facility Name: Emerald Estates

Address: 1577 East Myrtle (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: 309-647-6604 **Fax #** 309-647-0440

HFS ID Number:

Date of Initial License for Current Owners: 10/26/94

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Stephanie A. Price **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 10/1/19 to 9/30/20 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) 1/26/2021 (Date)
(Print Name and Title) Stephanie A. Price, CPA, Senior Manager
(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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	5,841	6
7	16	TOTALS	16	5,841	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	5,643			5,643	13
14	TOTALS	5,643			5,643	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1993 NO [ ]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 9/30/2020

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	16,895	3,837	1,471	22,203		22,203		22,203			1
2	Food Purchase		33,229		33,229		33,229		33,229			2
3	Housekeeping	44,857	3,929		48,786		48,786		48,786			3
4	Laundry		1,624		1,624		1,624		1,624			4
5	Heat and Other Utilities			18,514	18,514		18,514		18,514			5
6	Maintenance		2,205	6,908	9,113		9,113		9,113			6
7	Other (specify):* Disposal/garbage			1,273	1,273		1,273		1,273			7
8	TOTAL General Services	61,752	44,824	28,166	134,742		134,742		134,742			8
	B. Health Care and Programs											
9	Medical Director			1,950	1,950		1,950		1,950			9
10	Nursing and Medical Records	162,682	4,838	10,240	177,760		177,760		177,760			10
10a	Therapy			698	698		698		698			10a
11	Activities	17,792	730		18,522		18,522		18,522			11
12	Social Services	53,560			53,560		53,560		53,560			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			240,747	240,747		240,747	(240,747)				15
16	TOTAL Health Care and Programs	234,034	5,568	253,635	493,237		493,237	(240,747)	252,490			16
	C. General Administration											
17	Administrative	30,514		4	30,518		30,518	(4)	30,514			17
18	Directors Fees											18
19	Professional Services			7,619	7,619		7,619		7,619			19
20	Dues, Fees, Subscriptions & Promotions			2,234	2,234		2,234	(555)	1,679			20
21	Clerical & General Office Expenses		4,541	6,747	11,288		11,288		11,288			21
22	Employee Benefits & Payroll Taxes			41,607	41,607		41,607	(6)	41,601			22
23	Inservice Training & Education			280	280		280		280			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,999	9,999	(1,702)	8,297		8,297			25
26	Insurance-Prop.Liab.Malpractice			5,074	5,074		5,074		5,074			26
27	Other (specify):* Contributions			23	23		23	(23)				27
28	TOTAL General Administration	30,514	4,541	73,587	108,642	(1,702)	106,940	(588)	106,352			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	326,300	54,933	355,388	736,621	(1,702)	734,919	(241,335)	493,584			29

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

Facility Name & ID Number Emerald Estates #0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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			3,158	3,158		3,158	10,529	13,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,984	3,984		3,984	2,457	6,441			32
33	Real Estate Taxes			13,318	13,318		13,318		13,318			33
34	Rent-Facility & Grounds			33,696	33,696		33,696	(33,696)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State repl tax			863	863		863	(863)				36
37	**TOTAL Ownership**			55,019	55,019		55,019	(21,573)	33,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,702	1,702		1,702			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,818	40,818		40,818		40,818			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			40,818	40,818	1,702	42,520		42,520			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	326,300	54,933	451,225	832,458		832,458	(262,908)	569,550			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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(240,747)	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	(455)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4)	17		18
19	Entertainment	(6)	22		19
20	Contributions	(23)	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	(100)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(863)	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)**	$ (242,198)		$	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)	(20,710)	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,710)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (262,908)		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		$ 1,702	25	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,702		47

Emerald Estates

ID# 0039354

Report Period Beginning: 10/1/19

Ending: 9/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(240,747)	0	0	0	0	0	0	0	0	0	0	(240,747)	15
16	**TOTAL Health Care and Programs**	(240,747)	0	0	0	0	0	0	0	0	0	0	(240,747)	16
	C. General Administration													
17	Administrative	(4)	0	0	0	0	0	0	0	0	0	0	(4)	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	(555)	0	0	0	0	0	0	0	0	0	0	(555)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(6)	0	0	0	0	0	0	0	0	0	0	(6)	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):*	(23)	0	0	0	0	0	0	0	0	0	0	(23)	27
28	**TOTAL General Administration**	(588)	0	0	0	0	0	0	0	0	0	0	(588)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,335)	0	0	0	0	0	0	0	0	0	0	(241,335)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Estates # 0039354 **Report Period Beginning:** 10/1/19 **Ending:** 9/30/20

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	10,529	0	0	0	0	0	0	0	0	0	10,529	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,457	0	0	0	0	0	0	0	0	0	2,457	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(33,696)	0	0	0	0	0	0	0	0	0	(33,696)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(863)	0	0	0	0	0	0	0	0	0	0	(863)	36
37	**TOTAL Ownership**	(863)	(20,710)	0	0	0	0	0	0	0	0	0	(21,573)	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)**	(242,198)	(20,710)	0	0	0	0	0	0	0	0	0	(262,908)	45

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	TwoCan, Inc	100.00%	$ 6,970	$ 6,970	1
2	V	32	Interest		TwoCan, Inc	100.00%	626	626	2
3	V	34	Rent	29,496	TwoCan, Inc	100.00%		(29,496)	3
4	V	30	Depreciation		RLG Real Estate, LLC	100.00%	3,559	3,559	4
5	V	32	Interest		RLG Real Estate, LLC	100.00%	1,831	1,831	5
6	V	34	Rent	4,200	RLG Real Estate, LLC	100.00%		(4,200)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 33,696			$ 12,986	$ * (20,710)	14

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 11,401	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	$ 11,401		13

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 389,200	$ 253,798		3.7500	$ 5,265	1
2	Related Parties	X		Interest Income							(501)	2
3												3
4												4
5												5
	Working Capital											
6	Hickory Point Bank		X	Working Capital		9/16/16	98,000			3.2500	1,775	6
7	Hickory Point Bank		X	Interest Income							(98)	7
8												8
9	TOTAL Facility Related						$ 487,200	$ 253,798			$ 6,441	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 487,200	$ 253,798			$ 6,441	15

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

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 11,186	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 13,860	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,674	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,644	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.		$ 13,318	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	11,801	8
	2016	12,416	9
	2017	12,039	10
	2018	12,106	11
	2019	12,397	12

Line 2, R/E taxes paid: Emerald Estates bill $12,397 + $1,463 Central Office bill = $13,860

Line 4, R/E tax accrual: 9/12 Emerald Estates bill $9,298 + $1,347 Central Office bill = $10,644

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Estates COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0039354

CONTACT PERSON REGARDING THIS REPORT Stephanie A. Price, CPA

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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-102-008	Sect/Lot: 08 Village Square Subdiv	$ 453.30	$ 453.30
2.	09-08-25-102-009	Sect/Lot: 09 Village Square Subdiv	$ 11,490.36	$ 11,490.36
3.	09-08-25-102-007	Sect/Lot: 07 Village Square Subdiv	$ 453.30	$ 453.30
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 12,396.96	$ 12,396.96

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,642	1993	$ 18,934	1
2					2
3	TOTALS	29,642		$ 18,934	3

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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		1993	1989	$ 273,944	$	39	$ 6,970	$ 6,970	$ 190,607	4
5											5
6											6
7											7
8	Central Office		2005		132,849		39	3,559	3,559	24,226	8
	Improvement Type**										
9	Remodeling, flooring			1996	10,099		20			10,099	9
10	Remodeling, flooring			1996	6,110	157	20	157		3,773	10
11	Driveway			1999	11,000		20			11,000	11
12	Water Heater			2005	2,000		39			2,000	12
13	Carpet			2004	3,007		7			3,007	13
14	New sinks and faucets			2005	1,190		20			1,190	14
15	Bathroom remodeling - new plumbing, flooring, walls			2006	12,862	330	7	330		4,562	15
16	Bathroom remodeling - new plumbing, flooring, walls			2007	6,709	172	7	172		2,293	16
17	Carpet - Entire facility			2012	8,188		5			8,188	17
18	Roof			2013	20,197	518	39	518		3,582	18
19	Ramp, deck, sidewalk			2014	3,819	98	39	98		596	19
20	Shower unit with grab bars, new pedastal lavatory, faucet, drain.			2016	3,260	83	39	83		383	20
21	New Deck and Ramp			2017	6,602	169	39	169		494	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	Central Office - tracklights & receptacles			2009	216	9	20	9		104	31
32	New roof			2012	3,133	67	39	67		529	32
33	Permanent landscaping			2015	1,203	101	10	101		514	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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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)		$ 506,388	$ 1,704		$ 12,233	$ 10,529	$ 267,147	70

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 96,714	$ 1,244	$ 1,244	$		$ 93,327	71
72	Current Year Purchases	4,400	210	210			210	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 101,114	$ 1,454	$ 1,454	$		$ 93,537	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2011 Ford E350 Van	2011	$ 34,164	$	$	$	5	$ 34,164	76
77										77
78										78
79										79
80	TOTALS			$ 34,164	$	$	$		$ 34,164	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 660,600	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,158	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,687	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,529	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 394,848	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	Vehicle - Range Rover	$ 10,892	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 10,892	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 Emerald Estates **#** 0039354 **Report Period Beginning:** 10/1/19 **Ending:** 9/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/20 **(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	$ 11,734	$ 83,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	106,596	541,968	3
4	Supply Inventory (priced at cost)	1,555	7,192	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,994	85,674	7
8	Accounts Receivable (owners or related parties)	286,186	2,044,183	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 418,065	$ 2,762,831	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,550	13
14	Buildings, at Historical Cost		311,689	14
15	Leasehold Improvements, at Historical Cost	99,595	313,803	15
16	Equipment, at Historical Cost	146,169	740,456	16
17	Accumulated Depreciation (book methods)	(180,014)	(997,791)	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)**	$ 65,750	$ 388,707	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 483,815	$ 3,151,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,752	$ 19,656	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,384	91,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	136	972	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,644	39,436	32
33	Accrued Interest Payable	423	3,025	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	806,085		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 839,424	$ 154,447	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	57,813	445,893	39
40	Mortgage Payable	253,798	1,812,846	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)**	$ 311,611	$ 2,258,739	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,151,035	$ 2,413,186	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (667,220)	$ 738,352	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 483,815	$ 3,151,538	48

***(See instructions.)**

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (796,495)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (796,495)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	187,565	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	(58,290)	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)**	$ 129,275	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)**	$ (667,220)	24 *

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 764,595	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 764,595	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	11,699	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	1,916	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,615	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule, PG 29	241,813	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 241,813	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,020,023	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	134,742	31
32	Health Care	493,237	32
33	General Administration	106,940	33
	B. Capital Expense		
34	Ownership	55,019	34
	C. Ancillary Expense		
35	Special Cost Centers	1,702	35
36	Provider Participation Fee	40,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 832,458	40
41	**Income before Income Taxes (line 30 minus line 40)****	187,565	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 187,565	43

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

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

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

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	1,126	1,149	13,252	11.53	9
10	Activity Assistants	451	454	4,540	10.00	10
11	Social Service Workers	2,480	2,480	53,560	21.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	929	1,005	13,803	13.73	14
15	Cook Helpers/Assistants	405	408	3,092	7.58	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,744	3,871	44,857	11.59	18
19	Laundry					19
20	Administrator	281	291	8,358	28.72	20
21	Assistant Administrator					21
22	Other Administrative	269	291	11,401	39.18	22
23	Office Manager					23
24	Clerical	524	552	10,755	19.48	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)	13,210	13,599	162,682	11.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,419	24,100	$ 326,300 *	$ 13.54	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	$ 1,471	1,3	35
36	Medical Director	125/month	1,950	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	290	10,144	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				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychologist Consultant	9	697	10a,3	47
48	Psychiatrist Consultant			10a,3	48
49	TOTAL (lines 35 - 48)	329	$ 14,262		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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Grader	Admnistrative	100	$ 11,401
Jennifer Haseley	Office Assistant		7,681
Chelsea Hauschildt	Office Assistant		3,074
Nicki Palmer	Administrative		8,358
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 30,514

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
Eck, Schafer & Punke	CPA	$ 1,400
Sikich	CPA	6,091
Summit Tax & Acctg.	CPA	124
Shield Screening LLC	Security	4
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 7,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,732
Unemployment Compensation Insurance	2,592
FICA Taxes	24,962
Employee Health Insurance	6,224
Employee Meals	1,247
Illinois Municipal Retirement Fund (IMRF)*	
Employee Medical Expense	0
Other Employee Expense	1,844
TOTAL (agree to Schedule V, line 22, col.8)	$ 41,601

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Fees and Licenses	1,483
Dues and Subscriptions	196
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,679

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 Emerald Estates # 0039354 Report Period Beginning: 10/1/19 Ending: 9/30/20

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. $ **40,818**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **1,702**
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 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		10/1/19 - 9/30/20
Emerald Estates	#0039354	
Marigold Estates		
Patterson House		

Page 6, Part VII, Table B

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

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

	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:

The interest is allocated as follows:

Carlinville Estates	1,073
Emerald Estates	626
Marigold Estates	1,072
Patterson House	1,162
	3,933

Patterson House, Inc.		10/1/19 - 9/30/20
Carlinville Estates		
Emerald Estates	#0039354	
Marigold Estates		
Patterson House		

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability corporation, Richard Grader Real Estate LLC, 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	11,512

The interest is allocated as follows:

Carlinville Estates	3,140
Emerald Estates	1,831
Marigold Estates	3,140
Patterson House	3,401
	11,512

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

10/1/19 - 9/30/20

Page 7, Part VII, C

Owners' Compensation
10/1/19 - 9/30/20

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	Elin House (CILA)	Greykin House (CILA)
Richard L. Grader	81,439	19,545	11,401	19,545	21,174	4,072	5,702

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

#0039354

10/1/19 - 9/30/20

Owners' Compensation
10/1/19 - 9/30/20

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, 2020
The group consists of four DD homes (16 beds each) and two CILA homes (10 beds)
All costs of the central office and common costs are allocated as follows:
Carlinvile - 24%, Emerald - 14%, Marigold - 24%, Patterson - 26%, CILA's - 12%

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

	Total Expense	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House	CILA Homes	Line Ref
Food Costs	1,136	454	264	454	491	227	1
Housekeeping Supplies	597	102	60	102	110	51	3
Utilities	13,911	3,269	1,907	3,269	3,541	1,634	5
Maintenance	6,335	1,648	961	1,648	1,786	824	6
Nondepreciable equipment (consumable items)	669	140	99	157	169	17	7
Nursing Consultant fees	240	362	211	362	392	182	10
Administrative Salaries	197,394	46,803	27,301	46,802	50,703	23,401	17
Penalties	-						17
Professional Services	58,924	13,464	7,854	13,464	14,587	6,733	19
Dues, Fees and Subscriptions	5,329	1,895	1,106	1,895	2,053	948	20
Contributions	165	438	255	438	474	219	20
Advertising	-						20
Office Supplies	5,249	1,437	838	1,437	1,556	718	21
Other Office Expense	3,678	339	198	339	367	170	21
Postage	2,683	354	206	354	383	177	21
Telephone	10,356	2,663	1,553	2,663	2,885	1,331	21
Payroll Taxes	13,658	3,309	1,931	3,309	3,585	1,655	22
Group Health Insurance	67,522	14,747	8,603	14,747	15,976	7,374	22
Workers Comp Insurance	33,799	8,409	4,905	8,409	9,110	4,205	22
Business Meals	8,010	2,428	1,417	2,428	2,631	1,214	22
Entertainment	40	656	382	656	710	328	22
Other Employee Benefits	4,105	2,715	1,584	2,715	2,941	1,358	22
Inservice Training & Education	384	639	373	639	693	320	23
Other Admin/Staff Transportation	25,681	9,312	5,432	9,312	10,087	4,655	25
Insurance	43,389	7,594	4,430	7,594	8,227	3,796	26
Depreciation	3,326	809	472	809	877	405	30
Interest Expense	35,503	11,503	6,710	11,503	12,462	5,752	32
Real Estate Taxes	12,400	2,445	1,427	2,445	2,649	1,223	33
Lease - Central Office	30,000	7,200	4,200	7,200	7,800	3,600	34
IL replacement tax	6,166	480	280	480	520	240	36
	590,650	145,614	84,959	145,630	157,765	72,757	

Patterson House, Inc. 10/1/19 - 9/30/20
Carlinville Estates
Emerald Estates #0039354
Marigold Estates
Patterson House

Page 9, Part IX

Mortgage

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

Balance @ 9/30/20	1,812,846

Carlinville Estates	435,083
Emerald Estates	253,798
Marigold Estates	435,083
Patterson House	471,340

Patterson House, Inc.
Emerald Estates #0039354 10/1/19 - 9/30/20

Line 21, Other Medical Services

HAB Aid training reimbursement	-

Line 28, Other Revenue

Social Security	(1,482)
Earning Credits	834
Residents' travel reimbursement	1,702
Miscellaneous income	12
Workshop	240,747
	241,813

**Facility fiscal year end is 9/30/20, tax year end is 12/31/20.
Taxable income will not agree.

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.

Page 3, Part V

Line 25, Other Admin Staff Transportation

Vehicle expense	942
Vehicle fuel	1,335
Vehicle lease	1,938
Mileage	5,784
Medically necessary transportation	-
	9,999

**Facility fiscal year end is 9/30/20, tax year end is 12/31/20.
Taxable income will not agree.