		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: 0037341

Facility Name: Patterson House

Address: 307 East Jefferson (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: 217-728-4357 **Fax #** 217-728-2017

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
			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

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

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

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: 10/1/19 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,841	6
7	16	TOTALS	16	5,841	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,472			4,472	13
14	TOTALS	4,472			4,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.56%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 [X] Date 10/15/91 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 Patterson House # 0037341 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	32,953	1,756	1,217	35,926		35,926		35,926			1
2	Food Purchase		38,303		38,303		38,303		38,303			2
3	Housekeeping	48,256	3,533		51,789		51,789		51,789			3
4	Laundry		2,119		2,119		2,119		2,119			4
5	Heat and Other Utilities			24,819	24,819		24,819		24,819			5
6	Maintenance		1,215	9,230	10,445		10,445		10,445			6
7	Other (specify):* Disposal/garbage			1,776	1,776		1,776		1,776			7
8	**TOTAL General Services**	81,209	46,926	37,042	165,177		165,177		165,177			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	114,962	6,355	8,868	130,185		130,185		130,185			10
10a	Therapy			453	453		453		453			10a
11	Activities	28,725	2,614		31,339		31,339		31,339			11
12	Social Services	24,226		49	24,275		24,275		24,275			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			167,777	167,777		167,777	(167,777)				15
16	**TOTAL Health Care and Programs**	167,913	8,969	178,647	355,529		355,529	(167,777)	187,752			16
	C. General Administration											
17	Administrative	56,670		8	56,678		56,678	(8)	56,670			17
18	Directors Fees											18
19	Professional Services			14,123	14,123		14,123		14,123			19
20	Dues, Fees, Subscriptions & Promotions			3,299	3,299		3,299	(845)	2,454			20
21	Clerical & General Office Expenses		3,271	5,150	8,421		8,421		8,421			21
22	Employee Benefits & Payroll Taxes			49,833	49,833		49,833	(10)	49,823			22
23	Inservice Training & Education			820	820		820		820			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			12,371	12,371	(623)	11,748		11,748			25
26	Insurance-Prop.Liab.Malpractice			10,781	10,781		10,781		10,781			26
27	Other (specify):* Contributions			43	43		43	(43)				27
28	**TOTAL General Administration**	56,670	3,271	96,428	156,369	(623)	155,746	(906)	154,840			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	305,792	59,166	312,117	677,075	(623)	676,452	(168,683)	507,769			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,943	18,943		18,943	3,559	22,502			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,316	7,316		7,316	4,563	11,879			32
33	Real Estate Taxes			10,671	10,671		10,671		10,671			33
34	Rent-Facility & Grounds			7,900	7,900		7,900	(7,900)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* State repl tax			1,603	1,603		1,603	(1,603)				36
37	TOTAL Ownership			46,433	46,433		46,433	(1,381)	45,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					623	623		623			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,560	35,560		35,560		35,560			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,560	35,560	623	36,183		36,183			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	305,792	59,166	394,110	759,068		759,068	(170,064)	589,004			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: 10/1/19 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(167,777)	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	(845)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8)	17		18
19	Entertainment	(10)	22		19
20	Contributions	(43)	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		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,603)	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)**	$ (170,286)		$	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)	222	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (170,064)		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		$ 623	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)**			$ 623		47

STATE OF ILLINOIS

Patterson House

ID# 0037341

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 Patterson House # 0037341 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 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):*	(167,777)	0	0	0	0	0	0	0	0	0	0	(167,777)	15
16	**TOTAL Health Care and Programs**	(167,777)	0	0	0	0	0	0	0	0	0	0	(167,777)	16
	C. General Administration													
17	Administrative	(8)	0	0	0	0	0	0	0	0	0	0	(8)	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	(845)	0	0	0	0	0	0	0	0	0	0	(845)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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):*	(43)	0	0	0	0	0	0	0	0	0	0	(43)	27
28	**TOTAL General Administration**	(906)	0	0	0	0	0	0	0	0	0	0	(906)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(168,683)	0	0	0	0	0	0	0	0	0	0	(168,683)	29

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	3,559	0	0	0	0	0	0	0	0	0	3,559	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	4,563	0	0	0	0	0	0	0	0	0	4,563	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(7,900)	0	0	0	0	0	0	0	0	0	(7,900)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,603)	0	0	0	0	0	0	0	0	0	0	(1,603)	36
37	**TOTAL Ownership**	(1,603)	222	0	0	0	0	0	0	0	0	0	(1,381)	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)**	(170,286)	222	0	0	0	0	0	0	0	0	0	(170,064)	45

Facility Name & ID Number Patterson House # 0037341 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	32	Interest	$	TwoCan, Inc	100.00%	$ 1,162	$ 1,162	1
2	V	30	Depreciation		RLG Real Estate, LLC	100.00%	3,559	3,559	2
3	V	32	Interest		RLG Real Estate, LLC	100.00%	3,401	3,401	3
4	V	34	Rent	7,900	RLG Real Estate, LLC	100.00%		(7,900)	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			$ 7,900			$ 8,122	$ * 222	14

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

Facility Name & ID Number Patterson House # 0037341 Report Period Beginning: 10/1/19 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 Patterson House # 0037341 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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Richard L. Grader	President	Administration	100.00	See attached	10	20.00	Wages	$ 21,174	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	$ 21,174		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: 10/1/19 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 Patterson House # 0037341 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	$ 772,800	$ 471,340		3.7500	$ 9,694	1
2	Related Parties	X		Interest Income							(930)	2
3												3
4												4
5												5
	Working Capital											
6	Hickory Point Bank		X	Working Capital		9/16/16	182,000			5.0000	3,297	6
7	Hickory Point Bank		X	Interest Income							(182)	7
8												8
9	TOTAL Facility Related						$ 954,800	$ 471,340			$ 11,879	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 954,800	$ 471,340			$ 11,879	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description	Amount	
1	1. Real Estate Tax accrual used on 2019 report.	$ 6,006	1
2	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.)	$ 9,732	2
3	3. Under or (over) accrual (line 2 minus line 1).	$ 3,726	3
4	4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 6,945	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 10,671	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	6,675	8
2016	6,786	9
2017	6,474	10
2018	6,440	11
2019	7,016	12

FOR BHF USE ONLY

Line	Description	Amount	Line
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

Line 2, R/E taxes paid: Patterson House bill $7,016 + $2,716 Central Office bill = $9,732

Line 4, R/E tax accrual: 9/12 Patterson House bill $5,262 + Central Office bill $1,683 = $6,945

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 Patterson House COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0037341

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.	08-08-01-311-02	NE1/4 & E1/2 NW 1/4 Blk 7 Kellars	$ 7,015.56	$ 7,015.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,015.56	$ 7,015.56

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.

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 [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	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: 10/1/19 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		1991	1991	$ 230,924	$ 5,773	39	$ 5,773	$	$ 168,424	4
5											5
6											6
7											7
8	Central Office		2005		132,849		39	3,559	3,559	24,227	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	571	20	571		7,512	13
14	Bathroom/kitchen remodeling			2007	3,223	215	15	215		2,739	14
15	(2) exit doors			2008	3,866	258	15	258		3,050	15
16	(3) outswing entry doors			2009	3,025	202	15	202		2,202	16
17	(2) Furnaces			2013	7,991	205	39	205		1,503	17
18	Bathroom remodel - tub/shower surround, faucet, 2 assist bars			2016	6,598	169	39	169		677	18
19	Bathroom remodel, 2 mens' restrooms, doors, tile, paint, shower stalls, toil			2017	14,485	371	39	371		1,238	19
20	Bathroom remodel, 2 mens' restrooms, drywall, grout, backsplash			2017	1,488	38	39	38		127	20
21	EZ Shed			2020	4,529	125	15	125		125	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	17	20	17		192	31
32	New roof			2012	3,133	125	39	125		982	32
33	Permanent landscaping			2015	1,203	188	10	188		954	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: 10/1/19 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)		$ 451,901	$ 8,257		$ 11,816	$ 3,559	$ 240,913	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: 10/1/19 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	$ 148,467	$ 3,974	$ 3,974	$		$ 136,765	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 148,467	$ 3,974	$ 3,974	$		$ 136,765	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	$ 20,136	76
77										77
78										78
79										79
80	TOTALS			$ 33,561	$ 6,712	$ 6,712	$		$ 20,136	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)	$ 654,479	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,502	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,559	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 397,814	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.

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 Patterson House # 0037341 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.

Facility Name & ID Number Patterson House # 0037341 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	$ 21,766	$ 83,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	79,730	541,968	3
4	Supply Inventory (priced at cost)	767	7,192	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,275	85,674	7
8	Accounts Receivable (owners or related parties)	531,487	2,044,183	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 656,025	$ 2,762,831	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	311,689	311,689	14
15	Leasehold Improvements, at Historical Cost	7,363	313,803	15
16	Equipment, at Historical Cost	192,919	740,456	16
17	Accumulated Depreciation (book methods)	(373,588)	(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)**	$ 158,933	$ 388,707	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 814,958	$ 3,151,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,111	$ 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	14,701	91,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	253	972	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,945	39,436	32
33	Accrued Interest Payable	786	3,025	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	(738,350)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (710,554)	$ 154,447	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	124,880	445,893	39
40	Mortgage Payable	471,340	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)**	$ 596,220	$ 2,258,739	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (114,334)	$ 2,413,186	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 929,292	$ 738,352	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 814,958	$ 3,151,538	48

*(See instructions.)

Facility Name & ID Number Patterson House # 0037341 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**	$ 856,228	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 856,228	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,354	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)**	$ 73,064	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)**	$ 929,292	24 *

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

Facility Name & ID Number Patterson House # 0037341 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	$ 677,155	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 677,155	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	21,726	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	17,524	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 39,250	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	174,017	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 174,017	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 890,422	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	165,177	31
32	Health Care	355,529	32
33	General Administration	155,746	33
	B. Capital Expense		
34	Ownership	46,433	34
	C. Ancillary Expense		
35	Special Cost Centers	623	35
36	Provider Participation Fee	35,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 759,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	131,354	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 131,354	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 Patterson House # 0037341 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	309	331	4,424	13.37	9
10	Activity Assistants	2,005	2,020	24,301	12.03	10
11	Social Service Workers	1,260	1,266	24,226	19.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	541	614	9,574	15.59	14
15	Cook Helpers/Assistants	1,925	2,003	23,379	11.67	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,912	3,941	48,256	12.24	18
19	Laundry					19
20	Administrator	522	541	15,523	28.69	20
21	Assistant Administrator					21
22	Other Administrative	499	541	21,174	39.14	22
23	Office Manager					23
24	Clerical	972	1,024	19,973	19.50	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)	9,102	9,297	114,962	12.37	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,047	21,578	$ 305,792 *	$ 14.17	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,217	1,3	35
36	Medical Director	350/month	1,500	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	251	8,796	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	1	49	12,3	45
46	Other(specify)				46
47	Psychologist Consultant	6	453	10a,3	47
48	Psychiatrist Consultant				48
49	TOTAL (lines 35 - 48)	283	$ 12,015		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Patterson House # 0037341 | Report Period Beginning: 10/1/19 | Ending: 9/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Grader	Administrative	100	$ 21,174
Jennifer Haseley	Office Assistant		14,264
Chelsea Hauschildt	Office Assistant		5,709
Nicki Palmer	Administrative		15,523
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 56,670

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
Eck, Schafer & Punke	CPA	$ 2,600
Sikich	CPA	11,285
Summit Tax & Acctg.	CPA	230
Shield Screening LLC	Security	8
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 14,123

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,788
Unemployment Compensation Insurance	62
FICA Taxes	23,393
Employee Health Insurance	11,552
Employee Meals	2,376
Illinois Municipal Retirement Fund (IMRF)*	
Employee Medical Expense	697
Other Employee Expense	2,955
TOTAL (agree to Schedule V, line 22, col.8)	$ 49,823

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	545
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Fees and Licenses	563
Dues and Subscriptions	1,346
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,454

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number **Patterson House** # **0037341** **Report Period Beginning:** **10/1/19** **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. $ **35,560**
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. $ **623**
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
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:

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
Marigold Estates
Patterson House #0037341

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability corporation, Richard Grader Real Estate LLC, 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
Marigold Estates
Patterson House #0037341

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. 10/1/19 - 9/30/20

Carlinville Estates
Emerald Estates
Marigold Estates
Patterson House #0037341

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
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 @ 9/30/20	1,812,846

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

Patterson House, Inc.
Patterson House #0037341 10/1/19 - 9/30/20

Line 21, Other Medical Services

HAB Aid training reimbursement	-

Line 28, Other Revenue

Social Security	-
Earning Credits	5,596
Residents' travel reimbursement	623
Miscellaneous income	21
Workshop	167,777
	174,017

**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	1,788
Vehicle fuel	2,479
Vehicle lease	3,600
Mileage	4,804
Medically necessary transportation	-
	12,671

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