FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 E Myrtle Bx 232 (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: David W. White, C.P.A. **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 10/1/12 to 9/30/13 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) Daniel P. Caulkins
(Title) Vice-President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) David W. White, C.P.A. — Partner
(Firm Name & Address) Sikich LLP, 132 South Water Street, Suite 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: 10/1/12 Ending: 9/30/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,503			5,503	13
14	TOTALS	5,503			5,503	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.23%

D. How many bed-hold days during this year were paid by the Department?
7 (Do not include bed-hold 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 12/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/93 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: 12/31/13 Fiscal Year: 9/30/13

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	21,654	2,072	1,235	24,961		24,961		24,961			1
2	Food Purchase		37,881		37,881		37,881		37,881			2
3	Housekeeping	39,204	4,153		43,357		43,357		43,357			3
4	Laundry		1,395		1,395		1,395		1,395			4
5	Heat and Other Utilities			16,269	16,269		16,269		16,269			5
6	Maintenance		11,506	10,602	22,108		22,108		22,108			6
7	Other (specify):* Garbage			2,386	2,386		2,386		2,386			7
8	**TOTAL General Services**	60,858	57,007	30,492	148,357		148,357		148,357			8
	B. Health Care and Programs											
9	Medical Director			800	800		800		800			9
10	Nursing and Medical Records	105,390	3,770	7,997	117,157		117,157		117,157			10
10a	Therapy			1,915	1,915		1,915		1,915			10a
11	Activities	28,509	1,331		29,840		29,840		29,840			11
12	Social Services	32,580		1,653	34,233		34,233		34,233			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Workshop			249,570	249,570		249,570	(249,570)				15
16	**TOTAL Health Care and Programs**	166,479	5,101	261,935	433,515		433,515	(249,570)	183,945			16
	C. General Administration											
17	Administrative	59,198			59,198		59,198		59,198			17
18	Directors Fees											18
19	Professional Services			10,167	10,167		10,167		10,167			19
20	Dues, Fees, Subscriptions & Promotions			1,849	1,849		1,849	(662)	1,187			20
21	Clerical & General Office Expenses		5,158	6,738	11,896		11,896		11,896			21
22	Employee Benefits & Payroll Taxes			42,140	42,140		42,140	(202)	41,938			22
23	Inservice Training & Education			997	997		997		997			23
24	Travel and Seminar			138	138		138		138			24
25	Other Admin. Staff Transportation			7,984	7,984		7,984		7,984			25
26	Insurance-Prop.Liab.Malpractice			6,788	6,788		6,788		6,788			26
27	Other (specify):*											27
28	**TOTAL General Administration**	59,198	5,158	76,801	141,157		141,157	(864)	140,293			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	286,535	67,266	369,228	723,029		723,029	(250,434)	472,595			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: 10/1/12 Ending: 9/30/13

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			15,641	15,641		15,641	10,364	26,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,816	9,816		9,816	8,607	18,423			32
33	Real Estate Taxes			12,474	12,474		12,474		12,474			33
34	Rent-Facility & Grounds			35,796	35,796		35,796	(35,796)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			73,727	73,727		73,727	(16,825)	56,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,541	32,541		32,541		32,541			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			32,541	32,541		32,541		32,541			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	286,535	67,266	475,496	829,297		829,297	(267,259)	562,038			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: 10/1/12 Ending: 9/30/13

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	(249,570)	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	(302)	20		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(202)	22		19
20	Contributions	(145)	20		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	(215)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				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)**	$ (250,434)		$	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)	(16,825)	30,32,34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (16,825)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (267,259)		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	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Emerald Estates

ID# 0039354

Report Period Beginning: 10/1/12

Ending: 9/30/13

	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: 10/1/12 Ending: 9/30/13

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):*	(249,570)	0	0	0	0	0	0	0	0	0	0	(249,570)	15
16	**TOTAL Health Care and Programs**	(249,570)	0	0	0	0	0	0	0	0	0	0	(249,570)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(662)	0	0	0	0	0	0	0	0	0	0	(662)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(202)	0	0	0	0	0	0	0	0	0	0	(202)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(864)	0	0	0	0	0	0	0	0	0	0	(864)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(250,434)	0	0	0	0	0	0	0	0	0	0	(250,434)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	10,364	0	0	0	0	0	0	0	0	0	10,364	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	8,607	0	0	0	0	0	0	0	0	0	8,607	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(35,796)	0	0	0	0	0	0	0	0	0	(35,796)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(16,825)	0	0	0	0	0	0	0	0	0	(16,825)	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)**	(250,434)	(16,825)	0	0	0	0	0	0	0	0	0	(267,259)	45

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	50	Carlinville Estates	Carlinville	Two-Can, Inc.	Decatur	Landlord
Daniel P. Caulkins	50	Emerald Estates	Canton	R&D LLP	Decatur	Landlord
		Marigold Estates	Pekin			
		Patterson House	Sullivan			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Two-Can, Inc.	100.00%	$ 6,970	$ 6,970	1
2	V	32	Interest		Two-Can, Inc.	100.00%	2,418	2,418	2
3	V	34	Rent	29,496	Two-Can, Inc.	100.00%		(29,496)	3
4	V	30	Depreciation		R&D LLP	100.00%	3,394	3,394	4
5	V	32	Interest		R&D LLP	100.00%	6,189	6,189	5
6	V	34	Rent	6,300	R&D LLP	100.00%		(6,300)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 35,796			$ 18,971	$ * (16,825)	14

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	50.00	See attached	10	25.00	Wages	$ 19,729	17,1	1
2	Daniel P. Caulkins	Vice-President	Administration	50.00	See attached	10	25.00	Wages	19,729	17,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 39,458		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: 10/1/12 Ending: 9/30/13

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, Inc.
Street Address: 636 West Imboden
City / State / Zip Code: Decatur, IL 62521
Phone Number: ((217) 422-6510
Fax Number: ((217) 422-6819

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Attached Schedule				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Regions Bank		X	Mortgage		7/1/08	$ 525,000	$	7/1/13	Variable	$ 14,202	1
2	Town & Country Bank		X	Mortgage - refinanced		7/1/13	306,000	302,554	7/1/18	3.5000	3,030	2
3	Town & Country Bank		X	Vehicle Loan		11/14/11	22,500	8,590	11/14/15	3.9500	532	3
4	Related Parties	X		Interest Income							(487)	4
5												5
	Working Capital											
6	Town & Country Bank		X	Working Capital						4.5000	3,869	6
7	Town & Country Bank		X	Interest Income							(23)	7
8	State of Illinois		X	Interest Income							(2,700)	8
9	TOTAL Facility Related						$ 853,500	$ 311,144			$ 18,423	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 853,500	$ 311,144			$ 18,423	15

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

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 9,912	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.)		$ 12,792	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,880	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,594	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.		$ 12,474	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	9,181	8
	2009	9,703	9
	2010	10,026	10
	2011	10,649	11
	2012	10,811	12

Line 2, R/E taxes paid: Emerald Estates bill $10,811 + $1,981 Central Office bill = $12,792

Line 4, R/E taxes accrued: 9/12 Emerald Estates bill $8,108 + $1,486 Central Office bill = $9,594

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Emerald Estates COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0039354

CONTACT PERSON REGARDING THIS REPORT David W. White, C.P.A.

TELEPHONE (217) 423-6000 FAX #: (217) 423-6100

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-102-007	Village Sq Sub Div Sec 5, Lot 7	$ 395.10	$ 395.10
2.	09-08-25-102-008	Village Sq Sub Div Sec 5, Lot 8	$ 395.10	$ 395.10
3.	09-08-25-102-009	Village Sq Sub Div Sec 5, Lot 9	$ 10,020.46	$ 10,020.46
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,810.66	$ 10,810.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 10/1/12 Ending: 9/30/13

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).

None

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: 10/1/12 Ending: 9/30/13

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	$ 6,970	39	$ 6,970	$	$ 134,848	4
5											5
6											6
7											7
8	Central Office		2005		119,594	3,394	39	3,394		15,160	8
	Improvement Type**										
9	Remodeling, flooring			1996	10,099	505	20	505		8,626	9
10	Remodeling, flooring			1996	6,110	157	39	157		2,676	10
11	Driveway			1999	11,000	733	15	733		10,450	11
12	Water Heater			2001	2,000		7			2,000	12
13	Carpet			2004	3,007		5			3,007	13
14	New sinks and faucets			2004	1,190		7			1,190	14
15	Bathroom remodeling - new plumbing, flooring, walls			2006	12,862	330	39	330		2,254	15
16	Bathroom remodeling - new plumbing, flooring, walls			2007	6,708	172	39	172		1,089	16
17	Carpet			2012	8,188	1,170	7	1,170		1,755	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	Central Office - track lights and receptacles			2009	324	14	20	14		69	30
31	Central Office - new roof			2012	4,700	83	39	83		83	31
32											32
33											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: 10/1/12 Ending: 9/30/13

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)		$ 459,726	$ 13,528		$ 13,528	$	$ 183,207	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: 10/1/12 Ending: 9/30/13

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	$ 98,174	$ 5,646	$ 5,646	$		$ 78,256	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 98,174	$ 5,646	$ 5,646	$		$ 78,256	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	$ 6,831	$ 6,831	$	5	$ 13,096	76
77										77
78										78
79										79
80	TOTALS			$ 34,164	$ 6,831	$ 6,831	$		$ 13,096	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)	$ 610,998	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,005	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,005	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 274,559	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: 10/1/12 Ending: 9/30/13

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.

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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: 10/1/12 Ending: 9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/13 (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	$ 46,363	$ 272,685	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	119,079	458,549	3
4	Supply Inventory (priced at)	2,167	8,701	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,738	10,223	7
8	Accounts Receivable (owners or related parties)	259,975	1,529,266	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 429,322	$ 2,279,424	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		284,590	14
15	Leasehold Improvements, at Historical Cost	66,188	223,022	15
16	Equipment, at Historical Cost	132,338	503,470	16
17	Accumulated Depreciation (book methods)	(124,550)	(680,436)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		10,232	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,232)	20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Loan fees, net	2,515	14,794	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 76,491	$ 365,990	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 505,813	$ 2,645,414	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 10,289	$ 25,215	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,008	31,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,495	15,127	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,594	32,411	32
33	Accrued Interest Payable	706	4,153	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Intercompany	1,003,656		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,034,748	$ 108,101	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,590	50,528	39
40	Mortgage Payable	302,554	1,779,730	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)**	$ 311,144	$ 1,830,258	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,345,892	$ 1,938,359	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (840,079)	$ 707,055	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 505,813	$ 2,645,414	48

*(See instructions.)

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (849,835)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (849,835)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,756	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	(30,000)	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)**	$ 9,756	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)**	$ (840,079)	24 *

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

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	$ 594,596	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 594,596	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,560	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 20,560	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	253,897	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 253,897	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 869,053	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	148,357	31
32	Health Care	433,515	32
33	General Administration	141,157	33
	B. Capital Expense		
34	Ownership	73,727	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,541	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 829,297	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,756	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,756	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 594,596	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)	$ 594,596	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: 10/1/12 Ending: 9/30/13

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	2,029	2,203	21,040	9.55	9
10	Activity Assistants	794	794	7,469	9.41	10
11	Social Service Workers	2,048	2,080	32,580	15.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,531	1,547	15,754	10.18	14
15	Cook Helpers/Assistants	547	547	5,900	10.79	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,807	4,049	39,204	9.68	18
19	Laundry					19
20	Administrator	316	437	13,173	30.14	20
21	Assistant Administrator					21
22	Other Administrative	794	874	39,458	45.15	22
23	Office Manager					23
24	Clerical	319	437	6,567	15.03	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)	10,296	10,732	105,390	9.82	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,481	23,700	$ 286,535 *	$ 12.09	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	26	$ 1,235	1,3	35
36	Medical Director	$100/mo	800	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	160	5,615	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	8	610	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,653	12,3	45
46	Other(specify)				46
47	Psychologist Consultant	22	1,305	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	246	$ 11,218		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: 10/1/12 Ending: 9/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard L. Grader	Administrative	50	$ 19,729
Daniel P. Caulkins	Administrative	50	19,729
Lora A. Dillman	Administrative		13,173
Jennifer Haseley	Office Assistant		6,567
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,198

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
Hill & White L.L.C.	CPA	$ 1,575
Sikich LLP	CPA	6,092
Fisher & Phillips	Legal	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,167

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,498
Unemployment Compensation Insurance	3,088
FICA Taxes	20,791
Employee Health Insurance	3,975
Employee Meals	1,001
Illinois Municipal Retirement Fund (IMRF)*	
Long Term Care Insurance	1,623
Employee Medical Expenses	3,357
Other Employee Expenses	2,605
TOTAL (agree to Schedule V, line 22, col.8)	$ 41,938

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	57
Health Care Worker Background Check	
(Indicate # of checks performed 13)	455
Patient Background Checks	
Dues and Subscriptions	622
Fees and Licenses	53
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,187

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	138
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 138

**See instructions.

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Emerald Estates # 0039354 Report Period Beginning: 10/1/12 Ending: 9/30/13

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?

(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. $ 32,541
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. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, Part V

Line 23 Inservice Training & Education

Consultants	997
	997

Line 25 Other Admin. Staff Transportation

Fuel	2,750
Mileage	4,658
Vehicle Maintenance	576
	7,984
Less special cost center - medically necessary transportation	-
	7,984

Page 6, Part VII, 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 Two-Can, Inc. on its mortgage was as follows:

Regions Bank	9,946
Town & Country Bank	1,413
	11,359

The interest is allocated as follows:

Carlinville Estates	2,945
Emerald Estates	2,418
Marigold Estates	2,945
Patterson House	3,051

	11,359

Page 6, Part VII, B

The Central Office building and land are owned by a related limited liability partnership, R&D LLP.
R&D LLP has the same shareholders as Patterson House, Inc.

R&D LLP has the following basis in the building:

Carlinville Estates	119,594
Emerald Estates	119,594
Marigold Estates	119,594
Patterson House	119,594

Interest accrued by R&D LLP on its mortgage was as follows:

Regions Bank	24,958
Town & Country Bank	4,113
	29,071

The interest is allocated as follows:

Carlinville Estates	7,537
Emerald Estates	6,189
Marigold Estates	7,537
Patterson House	7,808
	29,071

Patterson House, Inc. 10/1/12 - 9/30/13
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 7, Part VII, C

Owners' Compensation
10/1/12 - 9/30/13

	Total Compensation	Carlinville Estates	Emerald Estates	Marigold Estates	Patterson House
Richard L. Grader	88,568	22,745	19,729	22,745	23,348
Daniel P. Caulkins	88,567	22,745	19,729	22,745	23,349
	177,135	45,490	39,458	45,490	46,697

Patterson House, Inc. 10/1/12 - 9/30/13
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Owners' Compensation
10/1/12 - 9/30/13

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

Daniel P. Caulkins:

- Operations of the facilities
- Supervising employees
- Dealing with consultants
- Buying supplies
- Inspecting the facilities
- Locating residents
- Dealing with residents' families
- Dealing with government agencies

Both owners:

- 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.

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

Page 8, Part VIII, B

Allocation of Central Office Costs - Fiscal Year Ended September 30, 2013
The group consists of four DD homes - All with 16 beds.
All costs of the central office and common costs are allocated 25% to each facility until 3/31/13. After that, they were allocated in this percentage:
Carlinvile - 27%, Emerald - 17%, Marigold - 27%, Patterson - 29%

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	Line Ref
Food costs	1,533	395	331	395	412	1
Housekeeping Supplies	1,169	310	220	310	329	3
Utilities	10,768	2,782	2,308	2,782	2,896	5
Maintenance	6,290	1,599	1,427	1,599	1,665	6
Administrative Salaries	272,971	69,953	60,961	69,953	72,104	17
Professional Services	27,392	7,053	5,965	7,053	7,321	19
Dues, Fees and Subscriptions	3,565	924	751	924	966	20
Contributions	580	145	145	145	145	20
Office Supplies	3,157	812	697	812	836	21
Other Office Expense	4,973	1,276	1,099	1,276	1,322	21
Postage	5,089	1,318	1,082	1,318	1,371	21
Telephone	12,094	3,107	2,651	3,107	3,229	21
Payroll Taxes	17,295	4,457	3,759	4,457	4,622	22
Group Health Insurance	29,158	7,950	4,513	7,950	8,745	22
Long-Term Care Insurance	6,492	1,623	1,623	1,623	1,623	22
Workers Comp Insurance	28,223	7,449	5,391	7,449	7,934	22
Business Meals	2,622	677	564	677	704	22
Entertainment	1,009	261	214	261	273	22
Other Employee Benefits	5,489	1,378	1,347	1,378	1,386	22
Inservice Training & Educatior	3,588	931	735	931	991	23
Travel and seminars	432	108	108	108	108	24
Other Admin/Staff Transportat	24,004	6,271	4,892	6,271	6,570	25
Insurance	36,790	9,692	7,134	9,692	10,272	26
Depreciation	7,653	1,971	1,666	1,971	2,045	30

Interest Expense	58,850	15,137	12,917	15,137	15,659	32
Real Estate Taxes	10,231	2,637	2,220	2,637	2,737	33
Lease - Central Office	30,250	7,800	6,550	7,800	8,100	34
	611,667	158,016	131,270	158,016	164,365	

Patterson House, Inc. 10/1/12 - 9/30/13
Carlinville Estates
Emerald Estates (# 0039354)
Marigold Estates
Patterson House

Page 9, Part IX

Mortgage

The mortgage dated 7/1/13 at Town & Country Bank is allocated as follows:

Town & Country Bank - balance @ 9/30/13	1,779,730

Carlinville Estates	480,527
Emerald Estates	302,554
Marigold Estates	480,527
Patterson House	516,122

Page 19, Part XVII

Line 21 Other Medical Services

HAB Aid training reimbursement	20,560

Line 28 Other Revenue

Earning Credits	4,327
Workshop	249,570
	253,897

Facility fiscal year end is 9/30/13, tax year end is 12/31/13. Taxable income will not agree.

Page 23, 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.