

Facility Name & ID Number Ellner Terrace

0047803 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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 N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	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	5,465			5,465	13
14	TOTALS	5,465			5,465	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.58%

D. How many bed-hold days during this year were paid by the Department? None (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)
None

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 06/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/24/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number

Ellner Terrace

0047803

Report Period Beginning:

7/1/2012

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	13,733	1,443	1,324	16,500		16,500		16,500		1
2	Food Purchase		24,759		24,759		24,759		24,759		2
3	Housekeeping		2,135		2,135		2,135	11	2,146		3
4	Laundry		1,270		1,270		1,270		1,270		4
5	Heat and Other Utilities			11,133	11,133		11,133	57	11,190		5
6	Maintenance	9,538	2,283	5,626	17,447		17,447	205	17,652		6
7	Other (specify):*										7
8	TOTAL General Services	23,271	31,890	18,083	73,244		73,244	273	73,517		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	166,346	3,948	921	171,215		171,215		171,215		10
10a	Therapy			1,042	1,042		1,042		1,042		10a
11	Activities		542		542		542		542		11
12	Social Services			1,113	1,113		1,113		1,113		12
13	CNA Training										13
14	Program Transportation			3,485	3,485		3,485		3,485		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	166,346	4,490	7,761	178,597		178,597		178,597		16
	C. General Administration										
17	Administrative	6,675		106,110	112,785		112,785	(106,110)	6,675		17
18	Directors Fees							2,742	2,742		18
19	Professional Services			1,395	1,395		1,395	15,963	17,358		19
20	Dues, Fees, Subscriptions & Promotions			1,145	1,145		1,145	1,799	2,944		20
21	Clerical & General Office Expenses	1,508	1,712	8,118	11,338		11,338	51,104	62,442		21
22	Employee Benefits & Payroll Taxes			45,809	45,809		45,809	7,288	53,097		22
23	Inservice Training & Education			131	131		131		131		23
24	Travel and Seminar			3,023	3,023		3,023	2,381	5,404		24
25	Other Admin. Staff Transportation			1,261	1,261		1,261	796	2,057		25
26	Insurance-Prop.Liab.Malpractice			16,403	16,403		16,403	696	17,099		26
27	Other (specify):*										27
28	TOTAL General Administration	8,183	1,712	183,395	193,290		193,290	(23,341)	169,949		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	197,800	38,092	209,239	445,131		445,131	(23,068)	422,063		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.

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#0047803

Report Period Beginning:

7/1/2012

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,054	17,054		17,054	1,790	18,844			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,798	42,798		42,798	13,007	55,805			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,829	5,829			34
35	Rent-Equipment & Vehicles							1,181	1,181			35
36	Other (specify):*											36
37	TOTAL Ownership			59,852	59,852		59,852	21,807	81,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,926	3,039	6,965		6,965		6,965			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,270	37,270		37,270		37,270			42
43	Other (specify):* Non-allowable Costs			4,780	4,780		4,780	(4,780)				43
44	TOTAL Special Cost Centers		3,926	45,089	49,015		49,015	(4,780)	44,235			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	197,800	42,018	314,180	553,998		553,998	(6,041)	547,957			45

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

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				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	(774)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(487)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,780)	43		24
25	Fund Raising, Advertising and Promotional				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 See Page 5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,041)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (6,041)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		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

Ellner Terrace

ID# 0047803

Report Period Beginning: 7/1/2012

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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

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
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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	3 Housekeeping	\$	Progressive Housing, Inc.	100.00%	\$ 11	\$	11	1
2	V	5 Utilities		Progressive Housing, Inc.	100.00%	57		57	2
3	V	6 Maintenance		Progressive Housing, Inc.	100.00%	205		205	3
4	V	17 Administrative	106,110	Progressive Housing, Inc.	100.00%			(106,110)	4
5	V	18 Director Fees		Progressive Housing, Inc.	100.00%	2,742		2,742	5
6	V	19 Professional Services		Progressive Housing, Inc.	100.00%	15,963		15,963	6
7	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,799		1,799	7
8	V	21 Clerical and General Office	43	Progressive Housing, Inc.	100.00%	51,147		51,104	8
9	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	7,288		7,288	9
10	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	2,381		2,381	10
11	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	796		796	11
12	V	26 Insurance		Progressive Housing, Inc.	100.00%	696		696	12
13	V	30 Depreciation		Progressive Housing, Inc.	100.00%	1,790		1,790	13
14	Total		\$ 106,153			\$ 84,875	\$ *	(21,278)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32 Interest	\$ 440	Progressive Housing, Inc.	100.00%	\$ 13,447	\$ 13,007	15
16	V	34 Rent		Progressive Housing, Inc.	100.00%	5,829	5,829	16
17	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	1,181	1,181	17
18	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,261	1,261	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 440			\$ 21,718	\$ * 21,278	39

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

Facility Name & ID Number

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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			Sparta Terrace	Sparta				1
2			Taylorville Terrace	Taylorville				2
3			Aviston Terrace	Aviston	Progressive			3
4			Briarbrook Place	East Peoria	Housing, Inc.	Olympia Fields	ICF/DD Provider	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,136	3Hrs/MTG	1.00	Dir. Fees	\$ 464	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,137	3Hrs/MTG	1.00	Dir. Fees	463	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,137	3Hrs/MTG	1.00	Dir. Fees	463	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,137	3Hrs/MTG	1.00	Dir. Fees	463	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,375	3Hrs/MTG	1.00	Dir. Fees	425	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,136	3Hrs/MTG	1.00	Dir. Fees	464	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	170,483	1.18	2.95	Salary	8,559	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,301		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

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Edward Childers	Cora Flota	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	Larry Manson
Sparta Terrace	446	410	446	447	447	447	2,643	8,237
Ellner Terrace	464	425	464	463	463	463	2,742	8,559
Taylorville Terrace	519	475	519	518	518	518	3,067	9,597
Aviston Terrace	484	444	484	483	483	483	2,861	8,880
Briarbrook Place	534	490	534	535	535	535	3,163	9,847
Harris Place	516	474	516	517	517	517	3,057	9,579
Joshua Manor	462	425	462	463	463	463	2,738	8,469
Terra Estates	476	437	476	475	475	475	2,814	8,701
Park Place	455	417	455	454	454	454	2,689	8,379
Western Gardens	210	194	211	211	211	211	1,248	3,957
Galaxy	277	254	277	277	277	277	1,639	5,246
Cardinal	181	165	180	180	180	180	1,066	3,348
Bill Goat Hill	248	228	248	249	249	249	1,471	4,673
Country Club Hill	202	186	202	203	203	203	1,199	3,831
Lee Street	219	200	219	219	219	219	1,295	4,190
Baker Street	178	163	178	178	178	178	1,053	3,348
182nd Street	215	197	215	215	215	215	1,272	4,064
Osage	195	178	195	196	196	196	1,156	3,670
Oakwood	219	200	218	218	218	218	1,291	4,118
Blair	242	222	241	242	242	242	1,431	4,601
Lowell	236	217	236	237	237	237	1,400	4,440
Marquette	249	228	248	248	248	248	1,469	4,691
Cherry	234	214	234	234	234	234	1,384	4,422
Luella	302	277	302	303	303	303	1,790	5,819
Olivia	315	288	315	316	316	316	1,866	5,890
Huron	228	209	227	227	227	227	1,345	4,297
Wilshire	246	225	247	246	246	246	1,456	4,637
Constance	148	135	149	148	148	147	875	2,686
175th Place	271	248	272	271	270	271	1,603	5,121

Sauganash	0	0	0	0	0	0	0	0
Steger	417	383	417	416	417	417	2,467	7,824
Waltonville	36	31	36	35	35	35	208	3,921
Mt. Vernon	176	161	177	176	176	176	1,042	0
Total PHI	<u>9,600</u>	<u>8,800</u>	<u>9,600</u>	<u>9,600</u>	<u>9,600</u>	<u>9,600</u>	<u>56,800</u>	<u>179,042</u>

Facility Name & ID Number Ellner Terrace

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Report Period Beginning:

7/1/2012

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6/30/13

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 NO

Name of Related Organization Progressive Housing, Inc.
 Street Address 3615 Park Drive, Suite 100
 City / State / Zip Code Olympia Fields, IL 60461
 Phone Number (708) 283-1530
 Fax Number (708) 283-2470

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Budgeted Rev/Dir Cost 13,188,353	31	\$ 237		630,386	\$ 11	1
2	5	Utilities	Budgeted Rev/Dir Cost 13,188,353	31	1,184		630,386	57	2
3	6	Maintenance	Budgeted Rev/Dir Cost 13,188,353	31	6,456		630,386	205	3
4	18	Director Fees	Budgeted Rev/Dir Cost 13,188,353	31	56,800		630,386	2,742	4
5	19	Professional Services	Budgeted Rev/Dir Cost 13,188,353	31	233,624		630,386	15,963	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost 13,188,353	31	27,886		630,386	1,799	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost 13,188,353	31	1,068,896	964,998	630,386	51,147	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost 13,188,353	31	151,773		630,386	7,288	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost 13,188,353	31	41,254		630,386	2,381	9
10	25	Auto Expense	Budgeted Rev/Dir Cost 13,188,353	31	19,131		630,386	796	10
11	26	Insurance	Budgeted Rev/Dir Cost 13,188,353	31	14,561		630,386	696	11
12	30	Depreciation	Budgeted Rev/Dir Cost 13,188,353	31	37,448		630,386	1,790	12
13	32	Interest	Budgeted Rev/Dir Cost 13,188,353	31	281,328		630,386	13,447	13
14	34	Rent	Budgeted Rev/Dir Cost 13,188,353	31	119,600		630,386	5,829	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost 13,188,353	31	31,048		630,386	1,181	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost 13,188,353	31	63,622		630,386	1,261	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,154,848	\$ 964,998		\$ 106,593	25

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2012 report.		\$		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.)	2012	\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2008	_____	8	
	2009	_____	9	
	2010	_____	10	
	2011	_____	11	
	2012	_____	12	
	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 Ellner Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0047803

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () FAX #: ()

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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		TOTALS	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

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 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 Ellner Terrace

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior Wood/Siding Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2011</u>	<u>\$ 25,000</u>	1
2	<u>Allocated from Home Office</u>			<u>150</u>	2
3	TOTALS			\$ 25,150	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2011		\$ 475,000	\$ 11,875	40	\$ 11,875	\$	\$ 28,699	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvement		1996	1,100		15			1,100	9
10	Building Improvement		1998	659	33	15	33		659	10
11	Flooring and Trim		2001	1,205	80	15	80		949	11
12	Jany Plumbing Backflow Preventor		2006	549	37	15	37		267	12
13	Bathroom Remodel		2006	2,038	136	15	136		915	13
14	Bathroom Remodel		2007	251	17	15	17		104	14
15	Furnace		2008	1,562	104	15	104		564	15
16	Dinning Room Remodel		2008	720	48	15	48		256	16
17	Bathroom Remodel		2008	514	34	15	34		182	17
18	Plumbing Improvement		2008	1,075	72	15	72		347	18
19	Plumbing Improvement		2008	1,895	126	15	126		610	19
20	Flooring and Trim		2008	1,885	126	15	126		598	20
21	Repair A/C		2011	627	42	15	42		80	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29	Allocation from Home Office			3,111			133	133	587	29
30										30
31										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 Ellner Terrace

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 492,191	\$ 12,730		\$ 12,863	\$ 133	\$ 35,917	70

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

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	\$ 35,882	\$ 3,604	\$ 3,604	\$	5-10Yrs	\$ 21,452	71
72	Current Year Purchases	1,785	53	53		5-10Yrs	53	72
73	Fully Depreciated Assets	16,469	42	42		5-10Yrs	16,469	73
74	Allocated From Home Office	13,165		1,359	1,359		10,214	74
75	TOTALS	\$ 67,301	\$ 3,699	\$ 5,058	\$ 1,359		\$ 48,188	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	Resident Transportation	2004 Ford Freestar	2004	\$ 19,386	\$	\$	\$	5	\$ 19,386	76
77	Resident Transportation	2004 Ford Lift Van	2004	30,995				5	30,995	77
78	Resident Transportation	Capitalized Repairs	2004/2012/2013	4,496	625	625		5	900	78
79	Allocated from Home Office			6,196		298	298		5,819	79
80	TOTALS			\$ 61,073	\$ 625	\$ 923	\$ 298		\$ 57,100	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)	\$ 645,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,844	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,790	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 141,205	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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		Allocated from Home Office			5,829			6
7	TOTAL				\$ 5,829			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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 N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 1,181 Description: Allocated from Home Office - postage machine, copier, storage

(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 Ellner Terrace # 0047803 Report Period Beginning: 7/1/2012 Ending: 6/30/13
 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	39(3)	visits			27	3,039					27		3,039		6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescrpts								3,926			3,926		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			\$		27	\$ 3,039	\$	3,926	\$	3,926	27	\$	6,965		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 Ellner Terrace

0047803

Report Period Beginning: 7/1/2012

Ending:

6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 52,373	\$ 52,373	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>9,567</u>)	119,776	119,776	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,450	2,450	6
7	Other Prepaid Expenses	1,450	1,450	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	91,650	91,650	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 267,699	\$ 267,699	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,150	13
14	Buildings, at Historical Cost	489,080	492,191	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	109,013	128,374	16
17	Accumulated Depreciation (book methods)	(124,643)	(141,205)	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 (spec <u>Loan Costs</u>	8,734	8,734	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 507,184	\$ 513,244	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 774,883	\$ 780,943	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 11,857	\$ 11,857	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,969	14,969	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,207	1,207	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,190	14,190	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	2,306	2,306	36
37	<u>Deposits/Deferred Income</u>	2,048	2,048	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 46,577	\$ 46,577	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	251,183	251,183	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)	\$ 251,183	\$ 251,183	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 297,760	\$ 297,760	46
47	TOTAL EQUITY(page 18, line 24)	\$ 477,123	\$ 483,183	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 774,883	\$ 780,943	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 379,925	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 379,925	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	55,031	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	()	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)	\$ 55,031	17
B. Transfers (Itemize):			
18	Allocation of Progressive Housing, Inc. Balance Sheet		18
19	to individual facilities	42,167	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 42,167	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 477,123	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 605,394	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 605,394	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	3,235	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,235	23
D. Non-Operating Revenue			
24	Contributions	400	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 400	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 609,029	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	73,244	31
32	Health Care	178,597	32
33	General Administration	193,290	33
B. Capital Expense			
34	Ownership	59,852	34
C. Ancillary Expense			
35	Special Cost Centers	11,745	35
36	Provider Participation Fee	37,270	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 553,998	40
41	Income before Income Taxes (line 30 minus line 40)**	55,031	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,031	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 605,394	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)	\$ 605,394	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#
FYE

Ellner Terrace
0047803
6/30/2013

SCH 19A

Schedule XVII
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)
and is part of a Consolidated Entity Tax Return.
Therefore, the Income or Loss cannot be
traced to the Federal Income Tax Return.

Facility Name & ID Number Ellner Terrace

0047803

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	486	524	11,174	21.32	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					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,587	1,659	13,733	8.28	15
16	Dishwashers					16
17	Maintenance Workers	837	971	9,538	9.82	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	176	201	6,675	33.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	68	76	1,508	19.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,796	2,229	29,173	13.09	29
30	Habilitation Aides (DD Homes)	13,499	14,455	125,999	8.72	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,449	20,115	\$ 197,800 *	\$ 9.83	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	20	\$ 1,060	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	2	50	L10, C3	38
39	Pharmacist Consultant	Monthly	871	L10, C3	39
40	Physical Therapy Consultant	5	349	L10a, C3	40
41	Occupational Therapy Consultant	7	465	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	228	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant	20	1,113	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	\$ 5,336		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
John Mirecki	Administrative	0	\$ 6,675	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance	14,245	Advertising: Employee Recruitment		
				FICA Taxes	14,946	Health Care Worker Background Check		
				Employee Health Insurance	11,291	(Indicate # of checks performed <u>26</u>)	265	
				Employee Meals	3,848	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	725	
						Miscellaneous Dues & Fees	155	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 6,675	Life Insurance	56	Allocated from Home Office	1,799	
(List each licensed administrator separately.)				Other Employee Benefits	1,423	Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount	Allocated from Home Office	7,288	Yellow page advertising	()	
Allocated from Progressive Housing, Inc.			\$ 106,110					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 53,097	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,944	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 106,110	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount	N/A				
Sheakly Payroll Service	Payroll Service		\$ 1,395				In-State Travel	
							Seminar Expense	3,023
							Allocated from Home Office	2,381
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,395	TOTAL		\$	TOTAL	\$ 5,404
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Ellner Terrace

0047803

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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. N/A
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N/A If YES, what is the capacity? N/A
- (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? 5-10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 101 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,270
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? No 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. \$ 3,848 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 73
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? Yes
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, LTD
- (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.