

Facility Name & ID Number Taylorville Terrace

0047795 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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,682			5,682	13
14	TOTALS	5,682			5,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.29%

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 08/02/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/08/1999 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

ACCRUAL 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

Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	17,954	1,728	1,721	21,403		21,403		21,403		1
2	Food Purchase		27,686		27,686		27,686		27,686		2
3	Housekeeping		1,477		1,477		1,477	13	1,490		3
4	Laundry		980		980		980		980		4
5	Heat and Other Utilities			11,629	11,629		11,629	64	11,693		5
6	Maintenance	7,586	1,913	4,427	13,926		13,926	229	14,155		6
7	Other (specify):*										7
8	TOTAL General Services	25,540	33,784	17,777	77,101		77,101	306	77,407		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	200,499	8,492	4,591	213,582		213,582		213,582		10
10a	Therapy										10a
11	Activities		3,425		3,425		3,425		3,425		11
12	Social Services			2,315	2,315		2,315		2,315		12
13	CNA Training										13
14	Program Transportation			4,030	4,030		4,030		4,030		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	200,499	11,917	15,736	228,152		228,152		228,152		16
	C. General Administration										
17	Administrative	20,250		112,094	132,344		132,344	(112,094)	20,250		17
18	Directors Fees							3,067	3,067		18
19	Professional Services			1,556	1,556		1,556	14,244	15,800		19
20	Dues, Fees, Subscriptions & Promotions			1,298	1,298		1,298	1,530	2,828		20
21	Clerical & General Office Expenses	1,536	4,045	9,931	15,512		15,512	57,823	73,335		21
22	Employee Benefits & Payroll Taxes			50,279	50,279		50,279	8,182	58,461		22
23	Inservice Training & Education			147	147		147		147		23
24	Travel and Seminar			591	591		591	1,557	2,148		24
25	Other Admin. Staff Transportation			1,557	1,557		1,557	889	2,446		25
26	Insurance-Prop.Liab.Malpractice			20,807	20,807		20,807	790	21,597		26
27	Other (specify):*										27
28	TOTAL General Administration	21,786	4,045	198,260	224,091		224,091	(24,012)	200,079		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	247,825	49,746	231,773	529,344		529,344	(23,706)	505,638		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

Taylorville Terrace

#0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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			23,460	23,460	23,460	2,007	25,467				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,163	44,163	44,163	12,082	56,245				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						6,502	6,502				34
35	Rent-Equipment & Vehicles						1,320	1,320				35
36	Other (specify):*											36
37	TOTAL Ownership			67,623	67,623	67,623	21,911	89,534				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,659	587	2,246	2,246		2,246				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,722	41,722	41,722		41,722				42
43	Other (specify):* Non-allowable Costs			5,360	5,360	5,360	(5,360)					43
44	TOTAL Special Cost Centers		1,659	47,669	49,328	49,328	(5,360)	43,968				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	247,825	51,405	347,065	646,295	646,295	(7,155)	639,140				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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0047795

Report Period Beginning: 7/1/2012

Ending: 6/30/13

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.)

		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	(1,298)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(497)	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	(5,360)	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)	\$ (7,155)		\$	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)	\$ (7,155)		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

Taylorville Terrace

ID# 0047795

Report Period Beginning: 7/1/2012

Ending: 6/30/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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
<u>Progressive Housing, Inc</u>	<u>100</u>	<u>See Pg 6-Supp</u>		<u>See Pg 6-Supp</u>		

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)		
1	V	<u>3 Housekeeping</u>	\$	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	\$ <u>13</u>	\$	<u>13</u>	1
2	V	<u>5 Utilities</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>64</u>		<u>64</u>	2
3	V	<u>6 Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>229</u>		<u>229</u>	3
4	V	<u>17 Administrative</u>	<u>112,094</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>			<u>(112,094)</u>	4
5	V	<u>18 Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>3,067</u>		<u>3,067</u>	5
6	V	<u>19 Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>14,244</u>		<u>14,244</u>	6
7	V	<u>20 Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,530</u>		<u>1,530</u>	7
8	V	<u>21 Clerical and General Office</u>	<u>44</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>57,867</u>		<u>57,823</u>	8
9	V	<u>22 Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>8,182</u>		<u>8,182</u>	9
10	V	<u>24 Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,557</u>		<u>1,557</u>	10
11	V	<u>25 Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>889</u>		<u>889</u>	11
12	V	<u>26 Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>790</u>		<u>790</u>	12
13	V	<u>30 Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,007</u>		<u>2,007</u>	13
14	Total		\$ <u>112,138</u>			\$ <u>90,439</u>	\$ *	<u>(21,699)</u>	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	\$ 2,998	Progressive Housing, Inc.	100.00%	\$ 15,080	\$ 12,082	15	
16	V	34 Rent		Progressive Housing, Inc.	100.00%	6,502	6,502	16	
17	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	1,320	1,320	17	
18	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,795	1,795	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		\$ 2,998			\$ 24,697	\$ *	21,699	39

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

Facility Name & ID Number

Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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			Aviston Terrace	Aviston				2
3			Ellner Terrace	Evansville	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 Taylorville Terrace # 0047795 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	9,081	3Hrs/MTG	1.00	Dir. Fees	\$ 519	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,082	3Hrs/MTG	1.00	Dir. Fees	518	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,082	3Hrs/MTG	1.00	Dir. Fees	518	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,082	3Hrs/MTG	1.00	Dir. Fees	518	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,325	3Hrs/MTG	1.00	Dir. Fees	475	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,081	3Hrs/MTG	1.00	Dir. Fees	519	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	169,445	1.18	2.95	Salary	9,597	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,664		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 Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

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		707,230	\$ 13	1
2	5	Utilities	Budgeted Rev/Dir Cost 13,188,353	31	1,184		707,230	64	2
3	6	Maintenance	Budgeted Rev/Dir Cost 13,188,353	31	6,456		707,230	229	3
4	18	Director Fees	Budgeted Rev/Dir Cost 13,188,353	31	56,800		707,230	3,067	4
5	19	Professional Services	Budgeted Rev/Dir Cost 13,188,353	31	233,624		707,230	14,244	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost 13,188,353	31	27,886		707,230	1,530	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost 13,188,353	31	1,068,896	964,998	707,230	57,867	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost 13,188,353	31	151,773		707,230	8,182	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost 13,188,353	31	41,254		707,230	1,557	9
10	25	Auto Expense	Budgeted Rev/Dir Cost 13,188,353	31	19,131		707,230	889	10
11	26	Insurance	Budgeted Rev/Dir Cost 13,188,353	31	14,561		707,230	790	11
12	30	Depreciation	Budgeted Rev/Dir Cost 13,188,353	31	37,448		707,230	2,007	12
13	32	Interest	Budgeted Rev/Dir Cost 13,188,353	31	281,328		707,230	15,080	13
14	34	Rent	Budgeted Rev/Dir Cost 13,188,353	31	119,600		707,230	6,502	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost 13,188,353	31	31,048		707,230	1,320	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost 13,188,353	31	63,622		707,230	1,795	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,154,848	\$ 964,998		\$ 115,136	25

Facility Name & ID Number

Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 950,598	\$ 860,622	08/15/26	6.7500	\$ 42,774						
2																	
3																	
4																	
5																	
Working Capital																	
6	Amortization										1,389						
7	Allocation from Home Office-Interest										14,417						
8	Allocation from Home Office-Amortization										663						
9	TOTAL Facility Related						\$ 950,598	\$ 860,622			\$ 59,243						
B. Non-Facility Related*																	
10																	
11																	
12									Interest Income Offset		(2,998)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,998)						
15	TOTALS (line 9+line14)						\$ 950,598	\$ 860,622			\$ 56,245						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
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	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2009	_____	9												
	2010	_____	10												
	2011	_____	11												
	2012	_____	12												

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 Taylorville Terrace COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0047795

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 Taylorville Terrace

0047795 Report Period Beginning:

7/1/2012 Ending:

6/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick/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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>14,000</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2	<u>Allocated from Home Office</u>			<u>168</u>	2
3	TOTALS	14,000		\$ 20,168	3

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning:

7/1/2012

Ending:

6/30/13

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	1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 257,590
5									
6									
7									
8									
	Improvement Type**								
9	Trash and Baffles	1998		2,435	82	15	82		2,435
10	Carpeting	2005		2,067	138	15	138		1,045
11	Bathroom Remodel	2007		4,867	324	15	324		2,102
12	Bathroom Remodel	2008		3,024	202	15	202		1,103
13	Fire Alarm Upgrade	2008		1,875	125	15	125		636
14	Concrete Sidewalk	2008		2,220	148	15	148		691
15	Plumbing Improvements to Water Heater	2010		516	34	15	34		114
16	New Air Conditioner - Women's wing	2010		4,336	289	15	289		903
17	New Roof (Net of Write off of Old Roof)	2012		4,615	810	15	810		964
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29	Allocation from Home Office			3,488			149	149	658
30									
31									
32									
33									
34									
35									
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 Taylorville 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)	\$ 759,443	\$ 20,402		\$ 20,551	\$ 149	\$ 268,241	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	\$ 17,797	\$ 2,437	\$ 2,437	\$	5-10Yrs	\$ 10,009	71
72	Current Year Purchases	1,388	140	140		5-10Yrs	140	72
73	Fully Depreciated Assets	17,830				5-10Yrs	17,830	73
74	Allocated From Home Office	14,762		1,524	1,524		11,454	74
75	TOTALS	\$ 51,777	\$ 2,577	\$ 4,101	\$ 1,524		\$ 39,433	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 Dodge Caravan/2005 Ford 1	2004/2005	\$ 35,558	\$	\$	\$	5	\$ 35,558	76
77	Resident Transportation	2004 Dodge Caravan	2008	950	190	190		5	918	77
78	Resident Transportation	2005 FORD Taurus	2008	1,453	291	291		5	1,333	78
79	Allocated from Home Office			6,948		334	334		6,526	79
80	TOTALS			\$ 44,909	\$ 481	\$ 815	\$ 334		\$ 44,335	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 876,297 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,460 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,467 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,007 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 352,009 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			6,502			6
7	TOTAL				\$ 6,502			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: \$ 1,320 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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.</p> <p>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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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		32	583		32	583	6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				1,659		1,659	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			\$	32	\$ 583	\$ 1,659	32	\$ 2,242	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 Taylorville Terrace

0047795

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	\$ 58,726	\$ 58,726	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,727</u>)	134,311	134,311	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,747	2,747	6
7	Other Prepaid Expenses	1,626	1,626	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	102,771	102,771	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 300,181	\$ 300,181	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,168	13
14	Buildings, at Historical Cost	759,175	759,443	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	74,976	96,686	16
17	Accumulated Depreciation (book methods)	(332,519)	(352,009)	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>	9,794	9,794	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 531,426	\$ 534,082	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 831,607	\$ 834,263	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 13,295	\$ 13,295	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,786	16,786	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,354	1,354	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,912	15,912	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	2,586	2,586	36
37	<u>Deposits/Deferred Income</u>	2,297	2,297	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 52,230	\$ 52,230	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	860,622	860,622	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)	\$ 860,622	\$ 860,622	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 912,852	\$ 912,852	46
47	TOTAL EQUITY(page 18, line 24)	\$ (81,245)	\$ (78,589)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 831,607	\$ 834,263	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (114,097)	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)	\$ (114,097)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	59,055	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)	\$ 59,055	17
B. Transfers (Itemize):			
18	Allocation of Progressive Housing, Inc. Balance Sheet		18
19	to individual facilities	(26,203)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (26,203)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (81,245)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Taylorville Terrace# 0047795Report Period Beginning: 7/1/2012

Ending:

6/30/13

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.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 692,331	1	
2	Discounts and Allowances for all Levels		2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 692,331	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	11,456	11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,456	23	
D. Non-Operating Revenue				
24	Contributions	1,563	24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,563	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)	\$ 705,350	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	77,101	31	
32	Health Care	228,152	32	
33	General Administration	224,091	33	
B. Capital Expense				
34	Ownership	67,623	34	
C. Ancillary Expense				
35	Special Cost Centers	7,606	35	
36	Provider Participation Fee	41,722	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 646,295	40	
41	Income before Income Taxes (line 30 minus line 40)**	59,055	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 59,055	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 692,331	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)	\$ 692,331	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

Taylorville Terrace
0047795
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 Taylorville Terrace

0047795

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				3
4	Licensed Practical Nurses	1,057	14,350	11.22	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	1,885	17,954	8.73	15
16	Dishwashers				16
17	Maintenance Workers	738	7,586	8.58	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	977	20,250	17.67	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	69	1,536	20.76	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,920	24,458	11.32	29
30	Habilitation Aides (DD Homes)	17,378	161,691	8.76	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	24,024	26,064	\$ 247,825 *	\$ 9.51 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	23	\$ 1,193	L1, C3 35
36	Medical Director	Monthly	4,800	L9, C3 36
37	Medical Records Consultant			37
38	Nurse Consultant	133	3,313	L10, C3 38
39	Pharmacist Consultant	Monthly	1,278	L10, C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	42	2,315	L12, C3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	198	\$ 12,899	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

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning: 7/1/2012

Ending: 6/30/13

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	
Chris Durbin	Administrator	0	\$ 20,250	Workers' Compensation Insurance	\$ 16,731	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,369	Advertising: Employee Recruitment		
				FICA Taxes	8,834	Health Care Worker Background Check		
				Employee Health Insurance	4,063	(Indicate # of checks performed <u>7</u>)	75	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	948	
						Miscellaneous Dues & Fees	275	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 20,250	Life Insurance	56	Allocated from Home Office	1,530	
(List each licensed administrator separately.)				Other Employee Benefits	1,226	Less: Public Relations Expense	()	
B. Administrative - Other				Allocated from Home Office	8,182	Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Allocated from Progressive Housing, Inc.			\$ 112,094					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 58,461			
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,828	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 112,094	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					
Sheakly Payroll Service	Payroll Service		\$ 1,556	N/A			In-State Travel	
							Seminar Expense	591
							Allocated from Home Office	1,557
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,556	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 2,148

* 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 Taylorville Terrace

0047795

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. \$ 3,891 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. \$ 41,722
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. \$ 4,063 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? 62
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.