

Facility Name & ID Number Terra Estates

0040352 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	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
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,903			4,903	13
14	TOTALS	4,903			4,903	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.96%

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 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/30/1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number

Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	12,208	2,431	1,077	15,716		15,716	15,716		1	
2	Food Purchase		27,393		27,393		27,393	27,393		2	
3	Housekeeping		4,251		4,251		4,251	4,251		3	
4	Laundry		1,299		1,299		1,299	1,299		4	
5	Heat and Other Utilities			12,742	12,742		12,742	12,742		5	
6	Maintenance	14,451	2,406	4,548	21,405		21,405	21,405		6	
7	Other (specify):*									7	
8	TOTAL General Services	26,659	37,780	18,367	82,806		82,806	82,806		8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	279,605	13,007	1,465	294,077		294,077	294,077		10	
10a	Therapy			6,020	6,020		6,020	6,020		10a	
11	Activities		981		981		981	981		11	
12	Social Services			1,022	1,022		1,022	1,022		12	
13	CNA Training									13	
14	Program Transportation			5,211	5,211		5,211	5,211		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	279,605	13,988	13,718	307,311		307,311	307,311		16	
	C. General Administration										
17	Administrative	17,630		97,190	114,820		114,820	(97,190)	17,630	17	
18	Directors Fees							2,698	2,698	18	
19	Professional Services			1,606	1,606		1,606	10,677	12,283	19	
20	Dues, Fees, Subscriptions & Promotions			2,413	2,413		2,413	3,868	6,281	20	
21	Clerical & General Office Expenses	1,867	2,744	6,343	10,954		10,954	50,355	61,309	21	
22	Employee Benefits & Payroll Taxes			95,313	95,313		95,313	6,603	101,916	22	
23	Inservice Training & Education			105	105		105		105	23	
24	Travel and Seminar			1,270	1,270		1,270	1,745	3,015	24	
25	Other Admin. Staff Transportation			2,780	2,780		2,780	477	3,257	25	
26	Insurance-Prop.Liab.Malpractice			6,202	6,202		6,202	99	6,301	26	
27	Other (specify):*									27	
28	TOTAL General Administration	19,497	2,744	213,222	235,463		235,463	(20,668)	214,795	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	325,761	54,512	245,307	625,580		625,580	(20,668)	604,912	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

Terra Estates

#0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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			16,831	16,831		16,831	(9,159)	7,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,556	30,556		30,556	10,683	41,239			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,767	5,767			34
35	Rent-Equipment & Vehicles							1,436	1,436			35
36	Other (specify):*											36
37	TOTAL Ownership			47,387	47,387		47,387	8,727	56,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,568		5,568		5,568		5,568			39
40	Barber and Beauty Shops			18	18		18		18			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,175	32,175		32,175		32,175			42
43	Other (specify):* Non-allowable Costs											43
44	TOTAL Special Cost Centers		5,568	32,193	37,761		37,761		37,761			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	325,761	60,080	324,887	710,728		710,728	(11,941)	698,787			45

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

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	(7,140)	30		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,433)	30		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	(1,067)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(301)	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				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	(16)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,957)		\$	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)	16		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 16		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (11,941)		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

Terra Estates

Report Period Beginning: 7/1/2013
 Ending: 6/30/2014

ID# 0040352

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Income against Office Supplies	\$ (16)	21	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		(16)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(97,190)	0	0	0	0	0	0	0	0	0	(97,190)	17
18	Directors Fees	0	2,698	0	0	0	0	0	0	0	0	0	2,698	18
19	Professional Services	0	10,677	0	0	0	0	0	0	0	0	0	10,677	19
20	Fees, Subscriptions & Promotions	0	3,868	0	0	0	0	0	0	0	0	0	3,868	20
21	Clerical & General Office Expenses	(16)	50,371	0	0	0	0	0	0	0	0	0	50,355	21
22	Employee Benefits & Payroll Taxes	0	6,603	0	0	0	0	0	0	0	0	0	6,603	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,745	0	0	0	0	0	0	0	0	0	1,745	24
25	Other Admin. Staff Transportation	0	477	0	0	0	0	0	0	0	0	0	477	25
26	Insurance-Prop.Liab.Malpractice	0	99	0	0	0	0	0	0	0	0	0	99	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(16)	(20,652)	0	0	0	0	0	0	0	0	0	(20,668)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16)	(20,652)	0	0	0	0	0	0	0	0	0	(20,668)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Terra Estates

0040352

Report Period Beginning:

7/1/2013 Ending:

6/30/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(10,573)	1,414	0	0	0	0	0	0	0	0	0	(9,159)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	10,683	0	0	0	0	0	0	0	0	10,683	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,767	0	0	0	0	0	0	0	0	5,767	34
35	Rent-Equipment & Vehicles	0	0	1,436	0	0	0	0	0	0	0	0	1,436	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,573)	1,414	17,886	0	8,727	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,368)	0	1,368	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,368)	0	1,368	0	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(11,957)	(19,238)	19,254	0	0	0	0	0	0	0	0	(11,941)	45

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	17 Administrative	\$ 97,190	Progressive Housing, Inc.	100.00%	\$	\$ (97,190)	1
2	V	18 Director Fees		Progressive Housing, Inc.	100.00%	2,698	2,698	2
3	V	19 Professional Services		Progressive Housing, Inc.	100.00%	10,677	10,677	3
4	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,868	3,868	4
5	V	21 Clerical and General Office		Progressive Housing, Inc.	100.00%	50,371	50,371	5
6	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	6,603	6,603	6
7	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,745	1,745	7
8	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	477	477	8
9	V	26 Insurance		Progressive Housing, Inc.	100.00%	99	99	9
10	V	30 Depreciation		Progressive Housing, Inc.	100.00%	1,414	1,414	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 97,190			\$ 77,952	\$ * (19,238)	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	\$	Progressive Housing, Inc.	100.00%	\$ 10,683	\$	10,683	15
16	V	34 Rent		Progressive Housing, Inc.	100.00%	5,767		5,767	16
17	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	1,436		1,436	17
18	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,368		1,368	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		\$			\$ 19,254	\$ *	19,254	39

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

Facility Name & ID Number

Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates	Hoyleton	Perfection			7
8			Park Place	Pana	Cleaning	Olympia Fields	Housekeeping	8
9			Cardinal	Woodlawn				9
10			Western Gardens	MT. Vernon				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 Terra Estates # 0040352 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	9,146	3Hrs/MTG	1.00	Dir. Fees	\$ 454	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,385	3Hrs/MTG	1.00	Dir. Fees	415	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,147	3Hrs/MTG	1.00	Dir. Fees	453	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,140	3Hrs/MTG	1.00	Dir. Fees	460	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,156	3Hrs/MTG	1.00	Dir. Fees	444	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,143	3Hrs/MTG	1.00	Dir. Fees	457	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	155,326	1.18	2.95	Salary	6,695	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,378		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	Misc Exp	Total	Larry Manson
Sparta Terrace	381	372	384	348	380	386	11	2,262	4,928
Ellner Terrace	469	459	473	429	468	476	17	2,791	5,777
Taylorville Terrace	479	469	483	438	478	487	17	2,851	7,907
Aviston Terrace	413	404	417	378	412	419	13	2,456	7,111
Briarbrook Place	481	471	486	440	481	488	16	2,863	7,047
Harris Place	444	434	448	406	443	451	15	2,641	6,894
Joshua Manor	382	374	385	350	407	388	(12)	2,274	4,851
Terra Estates	454	444	457	415	453	460	15	2,698	6,695
Park Place	449	439	452	410	448	455	15	2,668	6,703
Western Gardens	229	234	230	211	228	229	64	1,424	3,739
Galaxy	269	273	268	247	268	276	60	1,662	5,086
Cardinal	195	202	198	180	195	199	57	1,226	3,839
Bill Goat Hill	244	249	242	224	243	243	68	1,513	4,588
Country Club Hill	207	213	210	191	207	211	58	1,298	4,039
Lee Street	259	263	257	238	258	253	74	1,602	4,638
Baker Street	197	203	195	182	197	196	67	1,236	3,849
182nd Street	222	228	220	205	221	225	64	1,384	4,178
Osage	183	190	181	169	183	184	64	1,154	3,616
Oakwood	214	220	212	197	213	222	58	1,337	3,879
Blair	296	300	295	272	306	286	71	1,827	4,760
Lowell	260	264	258	239	259	260	69	1,609	4,831
Marquette	242	247	240	223	241	245	65	1,503	4,644
Cherry	229	234	227	211	228	235	61	1,426	4,266
Luella	222	228	219	205	221	228	60	1,383	5,231
Olivia	307	311	305	282	306	282	96	1,889	3,161
Huron	223	229	226	206	222	234	50	1,390	4,146
Wilshire	262	267	266	241	262	258	69	1,625	4,926
Constance	223	228	226	205	222	231	55	1,390	1,550
175th Place	265	270	264	244	265	263	71	1,643	5,015

Sauganash							0	0	4,256	
Steger	514	502	502	464	502	464	109	3,055	8,939	
Waltonville	186	182	187	166	185	171	31	1,108	3,402	
Mt. Vernon	200	197	187	184	198	195	33	1,193	3,530	
Total PHI	<u>9,600</u>	<u>9,600</u>	<u>9,600</u>	<u>8,800</u>	<u>9,600</u>	<u>9,600</u>	<u>1,581</u>	<u>58,381</u>	58,381	<u>162,021</u>

Facility Name & ID Number Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

7/30/2014

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	18	Director Fees	Budgeted Rev/Dir Cost	33	58,381		544,282	\$ 2,698	1
2	19	Professional Services	Budgeted Rev/Dir Cost	33	207,339		544,282	10,677	2
3	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	33	85,685		544,282	3,868	3
4	21	Clerical and General Office	Budgeted Rev/Dir Cost	33	1,086,305	1,000,711	544,282	50,371	4
5	22	Employee Benefits	Budgeted Rev/Dir Cost	33	158,964		544,282	6,603	5
6	24	Travel and Seminar	Budgeted Rev/Dir Cost	33	44,262		544,282	1,745	6
7	25	Auto Expense	Budgeted Rev/Dir Cost	33	9,781		544,282	477	7
8	26	Insurance	Budgeted Rev/Dir Cost	33	2,769		544,282	99	8
9	30	Depreciation	Budgeted Rev/Dir Cost	33	30,745		544,282	1,414	9
10	32	Interest	Budgeted Rev/Dir Cost	33	234,828		544,282	10,683	10
11	34	Rent	Budgeted Rev/Dir Cost	33	117,060		544,282	5,767	11
12	35	Equipment Rental	Budgeted Rev/Dir Cost	33	39,570		544,282	1,436	12
13	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	33	(6,363)		544,282	1,368	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,069,326	\$ 1,000,711		\$ 97,206	25

Facility Name & ID Number

Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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		7	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	\$ 803,567	\$ 624,821	08/15/26	6.7500	\$ 29,534	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Amortization										1,022	6						
7	Allocation from Home Office-Interest										11,344	7						
8	Allocation from Home Office-Amortization										569	8						
9	TOTAL Facility Related						\$ 803,567	\$ 624,821			\$ 42,469	9						
B. Non-Facility Related*																		
10												10						
11												11						
12									Interest Income Offset		(1,230)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,230)	14						
15	TOTALS (line 9+line14)						\$ 803,567	\$ 624,821			\$ 41,239	15						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 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.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2014 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:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Terra Estates COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040352

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 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Terra Estates

0040352

Report Period Beginning:

7/1/2013 Ending:

6/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,284 B. General Construction Type: Exterior 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	Facility	40,000	1993	\$ 20,000	1
2	Allocated from Home Office			130	2
3	TOTALS	40,000		\$ 20,130	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	1993	1989	\$ 406,000	\$ 13,584	40	\$ 10,150	\$ (3,434)	\$ 214,861	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements	1995		1,975		15			1,975	9
10	A.D.A. Shower	1999		2,164	72	15	73	1	2,164	10
11	Water Heater	2004		2,099	140	15	140		1,470	11
12	Bathroom Tile	2004		532	36	15	36		366	12
13	Kitchen Remodel	2004		1,317	88	15	88		850	13
14	Kitchen Cabinets	2004		4,346	290	15	290		2,778	14
15	Kitchen Counter Top	2004		675	45	15	45		431	15
16	Alarm Strobe Light Fixture	2005		800	53	15	53		483	16
17	Living Room Carpet	2005		1,105	74	15	74		634	17
18	Bathroom Remodel	2007		1,042	69	15	69		519	18
19	Bathroom Remodel	2007		757	50	15	50		351	19
20	Gazebo	2007		1,796	120	15	120		789	20
21	Bathroom Remodel	2008		665	44	15	44		283	21
22	Bathroom Remodel	2008		534	36	15	36		209	22
23	Building Improvements	2008		1,084	72	15	72		414	23
24	Replace fire panel	2011		1,145	76	15	76		234	24
25	Install 6 Sprinkler Heads	2012		1,185	79	15	79		197	25
26	New Furnace	2012		1,975	132	15	132		308	26
27	Flooring-3 Resident Rooms	2013		600	37	15	37		37	27
28	New Air Conditioner	2014		5,500	61	15	61		61	28
29										29
30										30
31	Allocation from Home Office			2,689			115	115	507	31
32										32
33	To offset Building Rent Income						(7,140)	(7,140)		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 Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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)	\$ 439,985	\$ 15,158		\$ 4,700	\$ (10,458)	\$ 229,921	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	\$ 9,661	\$ 1,026	\$ 1,026	\$	5-10Yrs	\$ 5,619	71
72	Current Year Purchases	7,071	366	366		10	366	72
73	Fully Depreciated Assets	27,151				5-10Yrs	27,151	73
74	Allocated from Home Office	11,381		1,041	1,041		8,830	74
75	TOTALS	\$ 55,264	\$ 1,392	\$ 2,433	\$ 1,041		\$ 41,966	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	2003 Mercury Sable Wagon	2003	\$ 16,961	\$	\$	\$	5	\$ 16,961	76
77	Resident Transportation	Capitalized Repairs	2007/2009/2011	2,734	281	281		5	1,793	77
78								5		78
79	Allocated from Home Office			6,167		258	258	5	5,031	79
80	TOTALS			\$ 25,862	\$ 281	\$ 539	\$ 258		\$ 23,785	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)	\$ 541,241	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,672	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,159)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 295,672	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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			5,767			6
7	TOTAL				\$ 5,767			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 1,436 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.

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. 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		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				5,568		5,568	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			\$		\$	5,568		\$ 5,568	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 Terra Estates# 0040352Report Period Beginning: 7/1/2013

Ending:

6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014

(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	\$ 76,082	\$ 76,082	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>8,270</u>)	40,778	40,778	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,262	5,262	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	80,014	80,014	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 202,136	\$ 202,136	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,130	13
14	Buildings, at Historical Cost	437,297	439,985	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	63,577	81,126	16
17	Accumulated Depreciation (book methods)	(283,444)	(295,672)	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>	6,380	6,380	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 243,810	\$ 251,949	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 445,946	\$ 454,085	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,628	\$ 11,628	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,447	15,447	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,315	1,315	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,766	11,766	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	5,094	5,094	36
37	<u>Deposits/Deferred Income</u>	1,256	1,256	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 46,506	\$ 46,506	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	624,821	624,821	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)	\$ 624,821	\$ 624,821	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 671,327	\$ 671,327	46
47	TOTAL EQUITY(page 18, line 24)	\$ (225,381)	\$ (217,242)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 445,946	\$ 454,085	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (214,506)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (214,506)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(87,527)	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)	\$ (87,527)	17
B. Transfers (Itemize):			
18	Allocation of Progressive Housing, Inc. Balance Sheet	76,652	18
19	to individual facilities		19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 76,652	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (225,381)	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	\$ 615,391	1	
2	Discounts and Allowances for all Levels		2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 615,391	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	7,140	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	612	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,752	23	
D. Non-Operating Revenue				
24	Contributions	58	24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58	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)	\$ 623,201	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	82,806	31	
32	Health Care	307,311	32	
33	General Administration	235,463	33	
B. Capital Expense				
34	Ownership	47,387	34	
C. Ancillary Expense				
35	Special Cost Centers	5,586	35	
36	Provider Participation Fee	32,175	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 710,728	40	
41	Income before Income Taxes (line 30 minus line 40)**	(87,527)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (87,527)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 615,391	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)	\$ 615,391	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	Terra Estates
ID#	0040352
FYE	6/30/2014

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 Terra Estates

0040352

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	551	12,340	21.65	3
4	Licensed Practical Nurses	3,592	54,864	14.64	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	1,369	12,208	8.34	15
16	Dishwashers				16
17	Maintenance Workers	1,008	14,451	13.68	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	604	17,630	27.00	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	64	1,867	27.87	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,334	17,038	11.40	29
30	Habilitation Aides (DD Homes)	20,409	195,363	9.04	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	28,931	325,761 *	10.62	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	\$ 1,077	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	L10, C3	39
40	Physical Therapy Consultant	19	609	L10a, C3	40
41	Occupational Therapy Consultant	249	5,411	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	19	1,022	L12, C3	45
46	Other(specify) <u>Dental</u>	6	465	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	313	\$ 9,584		49

C. CONTRACT NURSES

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

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 Terra Estates

0040352

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,062 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. \$ 32,175
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. \$ 5,230 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.