FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0047803

Facility Name: Ellner Terrace

Address: 801 Market Street (Number) Evansville (City) 62242 (Zip Code)

County: Randolph

Telephone Number: (618) 853-4451 **Fax #** (618) 853-2555

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1990

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2014 to 6/30/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Jessica Rosales
(Title) Chief Operating Officer

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,104			5,104	13
14	TOTALS	5,104			5,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.40%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X] 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 [X]

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	18,416	1,225	1,059	20,700		20,700		20,700			1
2	Food Purchase		22,652		22,652		22,652		22,652			2
3	Housekeeping		2,674		2,674		2,674		2,674			3
4	Laundry		1,633		1,633		1,633		1,633			4
5	Heat and Other Utilities			10,003	10,003		10,003	45	10,048			5
6	Maintenance	12,191	3,859	4,640	20,690		20,690	34	20,724			6
7	Other (specify):*											7
8	TOTAL General Services	30,607	32,043	15,702	78,352		78,352	79	78,431			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	154,132	4,216	2,876	161,224		161,224		161,224			10
10a	Therapy			35	35		35		35			10a
11	Activities		1,078		1,078		1,078		1,078			11
12	Social Services			1,347	1,347		1,347		1,347			12
13	CNA Training											13
14	Program Transportation			1,629	1,629		1,629		1,629			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	154,132	5,294	7,087	166,513		166,513		166,513			16
	C. General Administration											
17	Administrative	18,153		110,552	128,705		128,705	(110,552)	18,153			17
18	Directors Fees							3,227	3,227			18
19	Professional Services			2,243	2,243		2,243	7,958	10,201			19
20	Dues, Fees, Subscriptions & Promotions			1,467	1,467		1,467	3,574	5,041			20
21	Clerical & General Office Expenses	5,124	2,332	9,779	17,235		17,235	61,996	79,231			21
22	Employee Benefits & Payroll Taxes			57,091	57,091		57,091	8,500	65,591			22
23	Inservice Training & Education			374	374		374		374			23
24	Travel and Seminar			547	547		547	1,260	1,807			24
25	Other Admin. Staff Transportation			2,174	2,174		2,174	716	2,890			25
26	Insurance-Prop.Liab.Malpractice			5,400	5,400		5,400	243	5,643			26
27	Other (specify):*											27
28	TOTAL General Administration	23,277	2,332	189,627	215,236		215,236	(23,078)	192,158			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	208,016	39,669	212,416	460,101		460,101	(22,999)	437,102			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Ellner Terrace #0047803 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,775	17,775		17,775	1,739	19,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,606	37,606		37,606	11,785	49,391			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							1,537	1,537			35
36	Other (specify):*											36
37	**TOTAL Ownership**			55,381	55,381		55,381	15,061	70,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,350		4,350		4,350		4,350			39
40	Barber and Beauty Shops			10	10		10		10			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,909	36,909		36,909		36,909			42
43	Other (specify):* Disallowed Costs			30	30		30	(30)				43
44	**TOTAL Special Cost Centers**		4,350	36,949	41,299		41,299	(30)	41,269			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	208,016	44,019	304,746	556,781		556,781	(7,968)	548,813			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				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	(30)	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 Pg 5A	(7,938)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,968)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (7,968)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Ellner Terrace

ID# 0047803

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO Costs	$ (6,454)	43	1
2	Offset rental income against expense	(1,484)	34	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**	(7,938)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ellner Terrace # 0047803 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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	45	0	0	0	0	0	0	0	0	0	45	5
6	Maintenance	0	34	0	0	0	0	0	0	0	0	0	34	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	79	0	0	0	0	0	0	0	0	0	79	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	(110,552)	0	0	0	0	0	0	0	0	0	(110,552)	17
18	Directors Fees	0	3,227	0	0	0	0	0	0	0	0	0	3,227	18
19	Professional Services	0	7,958	0	0	0	0	0	0	0	0	0	7,958	19
20	Fees, Subscriptions & Promotions	0	3,575	0	0	0	0	0	0	0	0	0	3,574	20
21	Clerical & General Office Expenses	0	61,996	0	0	0	0	0	0	0	0	0	61,996	21
22	Employee Benefits & Payroll Taxes	0	8,500	0	0	0	0	0	0	0	0	0	8,500	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,260	0	0	0	0	0	0	0	0	0	1,260	24
25	Other Admin. Staff Transportation	0	715	0	0	0	0	0	0	0	0	0	715	25
26	Insurance-Prop.Liab.Malpractice	0	243	0	0	0	0	0	0	0	0	0	243	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(23,078)	0	0	0	0	0	0	0	0	0	(23,079)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(22,999)	0	0	0	0	0	0	0	0	0	(23,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ellner Terrace # 0047803 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,739	0	0	0	0	0	0	0	0	0	1,739	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,785	0	0	0	0	0	0	0	0	0	11,785	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,484)	0	1,484	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,537	0	0	0	0	0	0	0	0	1,537	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,484)	13,524	3,021	0	0	0	0	0	0	0	0	15,061	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):*	(6,484)	0	6,454	0	0	0	0	0	0	0	0	(30)	43
44	**TOTAL Special Cost Centers**	(6,484)	0	6,454	0	0	0	0	0	0	0	0	(30)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(7,968)	(9,475)	9,475	0	0	0	0	0	0	0	0	(7,969)	45

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 110,552	Progressive Housing, Inc.	100.00%	$	$ (110,552)	1
2	V	5	Utilities		Progressive Housing, Inc.	100.00%	45	45	2
3	V	6	Maintenance		Progressive Housing, Inc.	100.00%	34	34	3
4	V	18	Director Fees		Progressive Housing, Inc.	100.00%	3,227	3,227	4
5	V	19	Professional Services		Progressive Housing, Inc.	100.00%	7,958	7,958	5
6	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,575	3,575	6
7	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	61,996	61,996	7
8	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	8,500	8,500	8
9	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,260	1,260	9
10	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	715	715	10
11	V	26	Insurance		Progressive Housing, Inc.	100.00%	243	243	11
12	V	30	Depreciation		Progressive Housing, Inc.	100.00%	1,739	1,739	12
13	V	32	Interest		Progressive Housing, Inc.	100.00%	11,785	11,785	13
14	Total			$ 110,552			$ 101,077	$ * (9,475)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent		Progressive Housing, Inc.	100.00%	$ 1,484	$ 1,484	15
16	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	1,537	1,537	16
17	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	6,454	6,454	17
18	V								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			$			$ 9,475	$ * 9,475	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,141	3Hrs/MTG	1.00	Dir. Fees	$ 459	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,141	3Hrs/MTG	1.00	Dir. Fees	459	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	7,618	3Hrs/MTG	1.00	Dir. Fees	382	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,379	3Hrs/MTG	1.00	Dir. Fees	421	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,141	3Hrs/MTG	1.00	Dir. Fees	459	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,141	3Hrs/MTG	1.00	Dir. Fees	459	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	5,332	3Hrs/MTG	1.00	Dir. Fees	268	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,907		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

SEE ACCOUNTANTS' COMPILATION REPORT

Ellner Terrace
0047803
6/30/2015

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Cora Flota	Edward Childers	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Eileen Mullin	Misc Exp	Total
Sparta Terrace	366	366	366	366	305	335	213	263	2,579
Ellner Terrace	459	459	459	459	382	421	268	321	3,227
Taylorville Terrace	465	465	465	465	387	426	271	324	3,267
Aviston Terrace	397	397	397	397	331	364	232	282	2,799
Briarbrook Place	466	466	466	466	388	427	272	325	3,274
Harris Place	427	427	427	427	356	392	249	301	3,007
Joshua Manor	367	367	367	367	306	336	214	262	2,585
Terra Estates	442	442	442	442	368	405	258	310	3,107
Park Place	438	438	438	438	365	401	255	308	3,080
Western Gardens	236	236	236	236	197	216	138	162	1,658
Galaxy	273	273	273	273	227	250	159	187	1,914
Cardinal	204	204	204	204	170	187	119	144	1,433
Bill Goat Hill	249	249	249	249	207	228	145	172	1,747
Country Club Hill	214	214	214	214	178	196	125	147	1,503
Lee Street	267	267	267	267	222	245	156	180	1,870
Baker Street	205	205	205	205	171	188	120	141	1,442
182nd Street	228	228	228	228	190	209	133	156	1,603
Osage	189	189	189	189	158	173	110	131	1,329
Oakwood	220	220	220	220	183	202	128	151	1,543
Blair	305	305	305	305	254	280	178	209	2,142
Lowell	267	267	267	267	222	245	156	182	1,872
Marquette	247	247	247	247	206	226	144	169	1,732
Cherry	234	234	234	234	195	215	137	159	1,643
Luella	220	220	220	220	183	202	128	155	1,547
Olivia	310	310	310	310	258	284	181	209	2,173
Huron	228	228	228	228	190	209	133	156	1,603
Wilshire	269	269	269	269	224	246	157	184	1,886

Constance	236	236	236	236	197	216	138	162	1,658
175th Place	270	270	270	270	225	247	157	184	1,892
Sauganash	-	-	-	-	-	-	-	10	10
Steger	510	510	510	510	425	467	297	337	3,565
Waltonville	194	194	194	194	162	178	113	129	1,357
Mt. Vernon	200	200	200	200	166	183	116	135	1,400
Total BOD Expense	**9,600**	**9,600**	**9,600**	**9,600**	**8,000**	**8,800**	**5,600**	**6,647**	**67,447**

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: 20180 Governors Dr., Suite 300
City / State / Zip Code: Olympia Fields, IL 60461
Phone Number: (708) 283-1530
Fax Number: (708) 283-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Budgeted Rev/Dir Cost	13,171,654	33	939		469,685	$ 45	1
2	6	Maintenance	Budgeted Rev/Dir Cost	13,171,654	33	701		469,685	34	2
3	18	Director Fees	Budgeted Rev/Dir Cost	13,171,654	33	67,447		469,685	3,227	3
4	19	Professional Services	Budgeted Rev/Dir Cost	13,171,654	33	204,232		469,685	7,958	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	13,171,654	33	74,328		469,685	3,575	5
6	21	Clerical and General Office	Budgeted Rev/Dir Cost	13,171,654	33	1,291,500	1,101,919	469,685	61,996	6
7	22	Employee Benefits	Budgeted Rev/Dir Cost	13,171,654	33	178,040		469,685	8,500	7
8	24	Travel and Seminar	Budgeted Rev/Dir Cost	13,171,654	33	27,459		469,685	1,260	8
9	25	Auto Expense	Budgeted Rev/Dir Cost	13,171,654	33	14,968		469,685	715	9
10	26	Insurance	Budgeted Rev/Dir Cost	13,171,654	33	8,530		469,685	243	10
11	30	Depreciation	Budgeted Rev/Dir Cost	13,171,654	33	36,018		469,685	1,739	11
12	32	Interest	Budgeted Rev/Dir Cost	13,171,654	33	238,933		469,685	11,785	12
13	34	Rent	Budgeted Rev/Dir Cost	13,171,654	33	31,050		469,685	1,484	13
14	35	Equipment Rental	Budgeted Rev/Dir Cost	13,171,654	33	40,919		469,685	1,537	14
15	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	13,171,654	33	281,423		469,685	6,454	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,496,487	$ 1,101,919		$ 110,552	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 301,480	$ 174,085	08/15/26	6.7500	$ 37,606	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization											6
7	Allocation from Home Office-Interest										11,257	7
8	Allocation from Home Office-Amortization										591	8
9	TOTAL Facility Related						$ 301,480	$ 174,085			$ 49,454	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(63)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (63)	14
15	TOTALS (line 9+line14)						$ 301,480	$ 174,085			$ 49,391	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

N/A - Not for profit entity

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ellner Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0047803

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 X _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2011	$ 25,000	1
2	Allocated from Home Office			4,115	2
3	TOTALS			$ 29,115	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2011		$ 475,000	$ 11,875	40	$ 11,875	$	$ 52,449	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1996	1,100		15			1,100	9
10	Building Improvement			1998	659		15			659	10
11	Flooring and Trim (Replaced in 2014-See Line 24)			2001			15				11
12	Jany Plumbing Backflow Preventor			2006	549	37	15	37		341	12
13	Bathroom Remodel			2006	2,038	136	15	136		1,187	13
14	Bathroom Remodel			2007	251	17	15	17		138	14
15	Furnace			2008	1,562	104	15	104		772	15
16	Dinning Room Remodel			2008	720	48	15	48		352	16
17	Bathroom Remodel			2008	514	34	15	34		250	17
18	Plumbing Improvement			2008	1,075	72	15	72		491	18
19	Plumbing Improvement			2008	1,895	126	15	126		862	19
20	Flooring and Trim			2008	1,885	126	15	126		850	20
21	Repair A/C			2011	627	42	15	42		164	21
22	Repair A/C			2013	890	59	15	59		113	22
23	Installed Thermostat, Furnace Burner			2014	1,214	81	15	81		121	23
24	Replace Flooring			2014	1,310	87	15	87		94	24
25	Replace Flooring in 2 bedrooms			2014	1,949	130	15	130		130	25
26	Replace Sprinkler pendants			2014	3,365	159	15	159		159	26
27											27
28											28
29	Allocation from Home Office				14,750			348	348	885	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 511,353	$ 13,133		$ 13,481	$ 348	$ 61,117	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 36,438	$ 3,581	$ 3,581	$	5-10Yrs	$ 24,842	71
72	Current Year Purchases	2,876	134	134		10 Yrs	134	72
73	Fully Depreciated Assets	17,687				5-10Yrs	17,687	73
74	Allocated from Home Office	12,888		1,164	1,164		9,055	74
75	TOTALS	$ 69,889	$ 3,715	$ 4,879	$ 1,164		$ 51,718	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2004 Ford Freestar	2004	$ 19,386	$	$	$	5	$ 19,386	76
77	Resident Transportation	2004 Ford Lift Van	2004	30,995				5	30,995	77
78	Resident Transportation	Capitalized Repairs	2004/2012/2013	4,496	927	927		5	2,687	78
79	Allocated from Home Office			5,383		227	227		4,724	79
80	TOTALS			$ 60,260	$ 927	$ 1,154	$ 227		$ 57,792	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)	$ 670,617	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,775	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,514	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,739	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 170,627	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	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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		Allocated from Home Office			1,484			5
6		Offset rental income			(1,484)			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

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

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 1,537 Description: Allocated from Home Office - postage machine $75, copier $1015, storage $447
    (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				4,350		4,350	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			$		$	$ 4,350		$ 4,350	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,716	$ 27,716	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,214)	26,224	26,224	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,880	1,880	7
8	Accounts Receivable (owners or related parties)	80,546	80,546	8
9	Other(specify): Reserves/Deposits	69,229	69,229	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 205,595	$ 205,595	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	29,115	13
14	Buildings, at Historical Cost	496,603	511,353	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	111,878	130,149	16
17	Accumulated Depreciation (book methods)	(155,931)	(170,627)	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 (spe Loan costs	4,496	4,496	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 482,046	$ 504,486	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 687,641	$ 710,081	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,927	$ 7,927	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,627	13,627	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,400	2,400	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,693	9,693	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	6,193	6,193	36
37	Deposits/Deferred Income	812	812	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 40,652	$ 40,652	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	174,085	174,085	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)**	$ 174,085	$ 174,085	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 214,737	$ 214,737	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 472,904	$ 495,344	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 687,641	$ 710,081	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 447,607	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 447,607	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	25,297	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)**	$ 25,297	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 472,904	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 571,733	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 571,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,798	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,798	23
	D. Non-Operating Revenue		
24	Contributions	2,167	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,167	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	2,380	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,380	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 582,078	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	78,352	31
32	Health Care	166,513	32
33	General Administration	215,236	33
	B. Capital Expense		
34	Ownership	55,381	34
	C. Ancillary Expense		
35	Special Cost Centers	4,390	35
36	Provider Participation Fee	36,909	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 556,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,297	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,297	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 571,733	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)	$ 571,733	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	496	525	11,365	21.65	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,993	2,110	18,416	8.73	15
16	Dishwashers					16
17	Maintenance Workers	875	930	12,191	13.11	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	670	754	18,153	24.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	207	220	5,124	23.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	134	151	2,429	16.09	28
29	Resident Services Coordinator	1,582	1,647	21,355	12.97	29
30	Habilitation Aides (DD Homes)	12,528	13,226	118,983	9.00	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,485	19,563	$ 208,016 *	$ 10.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	20	$ 1,059	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,266	L10, C3	39
40	Physical Therapy Consultant	1	35	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	24	1,347	L12, C3	45
46	Other(specify) Dental	18	1,610	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	63	$ 6,517		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 6,620
Karla Rogers	Administrator	0	11,533
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 18,153

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 110,552
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 110,552

C. Professional Services

Vendor/Payee	Type	Amount
Sheakley Payroll Service	Payroll Service	$ 1,907
Paychex	Payroll Service	336
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 2,243

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,680
Unemployment Compensation Insurance	13,276
FICA Taxes	15,626
Employee Health Insurance	7,352
Employee Meals	3,703
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	54
Other Employee Benefits	400
Allocated from Home Office	8,500
TOTAL (agree to Schedule V, line 22, col.8)	$ 65,591

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 2)	70
Patient Background Checks	
Hiring Expense	1,082
Miscellaneous Dues & Fees	315
Allocated from Home Office	3,574
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,041

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	547
Allocated from Home Office	1,260
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,807

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace # 0047803 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ellner Terrace **#** 0047803 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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? **No** 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. $ **1,113** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,909**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,703** 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? **36**
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 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.