

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0047795</u></p> <p>Facility Name: <u>Taylorville Terrace</u></p> <p>Address: <u>921 East Market St</u> <u>Taylorville</u> <u>62568</u> <small>Number City Zip Code</small></p> <p>County: <u>Christian</u></p> <p>Telephone Number: <u>(217) 287-7787</u> Fax # <u>(217) 287-7743</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/02/1991</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td> <input checked="" type="checkbox"/> Charitable Corp.</td> <td> <input type="checkbox"/> Individual</td> <td> <input type="checkbox"/> State</td> </tr> <tr> <td> <input type="checkbox"/> Trust</td> <td> <input type="checkbox"/> Partnership</td> <td> <input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 C (3)</u></td> <td> <input type="checkbox"/> Corporation</td> <td> <input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td> <input type="checkbox"/> "Sub-S" Corp.</td> <td> <input type="checkbox"/> Limited Liability Co. _____</td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Trust</td> <td> <input type="checkbox"/> Other _____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>630-361-2868</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. _____		<input type="checkbox"/> Trust	<input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2014</u> to <u>6/30/2015</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Jessica Rosales</u> (Title) <u>Chief Operating Officer</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()</td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jessica Rosales</u> (Title) <u>Chief Operating Officer</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Terrace

0047795 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,904			4,904	13
14	TOTALS	4,904			4,904	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.97%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/02/1991

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

YES Date 03/08/1999 NO

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

YES NO If YES, enter number of beds certified _____ 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: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	18,205	1,731	1,412	21,348		21,348	21,348		1	
2	Food Purchase		26,830		26,830		26,830	26,830		2	
3	Housekeeping		1,272		1,272		1,272	1,272		3	
4	Laundry		1,288		1,288		1,288	1,288		4	
5	Heat and Other Utilities			10,778	10,778		10,778	45	10,823	5	
6	Maintenance	4,898	1,074	5,293	11,265		11,265	34	11,299	6	
7	Other (specify):*									7	
8	TOTAL General Services	23,103	32,195	17,483	72,781		72,781	79	72,860	8	
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800	4,800		9	
10	Nursing and Medical Records	166,422	7,004	4,551	177,977		177,977	177,977		10	
10a	Therapy									10a	
11	Activities		4,107		4,107		4,107	4,107		11	
12	Social Services			1,604	1,604		1,604	1,604		12	
13	CNA Training									13	
14	Program Transportation			4,634	4,634		4,634	4,634		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	166,422	11,111	15,589	193,122		193,122		193,122	16	
	C. General Administration										
17	Administrative	9,907		108,157	118,064		118,064	(108,157)	9,907	17	
18	Directors Fees							3,267	3,267	18	
19	Professional Services			4,171	4,171		4,171	9,903	14,074	19	
20	Dues, Fees, Subscriptions & Promotions			1,473	1,473		1,473	3,720	5,193	20	
21	Clerical & General Office Expenses	2,507	3,265	12,546	18,318		18,318	63,180	81,498	21	
22	Employee Benefits & Payroll Taxes			57,658	57,658		57,658	8,610	66,268	22	
23	Inservice Training & Education			466	466		466		466	23	
24	Travel and Seminar			752	752		752	1,275	2,027	24	
25	Other Admin. Staff Transportation			2,201	2,201		2,201	724	2,925	25	
26	Insurance-Prop.Liab.Malpractice			7,173	7,173		7,173	235	7,408	26	
27	Other (specify):*									27	
28	TOTAL General Administration	12,414	3,265	194,597	210,276		210,276	(17,243)	193,033	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	201,939	46,571	227,669	476,179		476,179	(17,164)	459,015	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

Taylorville Terrace

#0047795

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			23,754	23,754	23,754	1,759	25,513				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,968	38,968	38,968	9,395	48,363				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles						1,556	1,556				35
36	Other (specify):*											36
37	TOTAL Ownership			62,722	62,722	62,722	12,710	75,432				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,862		1,862	1,862		1,862				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,429	38,429	38,429		38,429				42
43	Other (specify):* Disallowed Costs											43
44	TOTAL Special Cost Centers		1,862	38,429	40,291	40,291		40,291				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	201,939	48,433	328,820	579,192	579,192	(4,454)	574,738				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 Taylorville Terrace

0047795

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	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				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	(4,454)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,454)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,454)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Taylorville Terrace

ID# 0047795

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallowed HO costs	\$ (2,951)	43	1
2	Offset rental income against expense	(1,503)	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		(4,454)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Terrace# 0047795

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	(108,157)	0	0	0	0	0	0	0	0	0	(108,157)	17
18	Directors Fees	0	3,267	0	0	0	0	0	0	0	0	0	3,267	18
19	Professional Services	0	9,903	0	0	0	0	0	0	0	0	0	9,903	19
20	Fees, Subscriptions & Promotions	0	3,720	0	0	0	0	0	0	0	0	0	3,720	20
21	Clerical & General Office Expenses	0	63,180	0	0	0	0	0	0	0	0	0	63,180	21
22	Employee Benefits & Payroll Taxes	0	8,610	0	0	0	0	0	0	0	0	0	8,610	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,275	0	0	0	0	0	0	0	0	0	1,275	24
25	Other Admin. Staff Transportation	0	724	0	0	0	0	0	0	0	0	0	724	25
26	Insurance-Prop.Liab.Malpractice	0	235	0	0	0	0	0	0	0	0	0	235	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(17,243)	0	0	0	0	0	0	0	0	0	(17,243)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	(17,164)	0	0	0	0	0	0	0	0	0	(17,164)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Terrace# 0047795

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	1,759	0	0	0	0	0	0	0	0	0	1,759	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	9,395	0	0	0	0	0	0	0	0	0	9,395	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,503)	0	1,503	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,556	0	0	0	0	0	0	0	0	1,556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,503)	11,154	3,059	0	0	0	0	0	0	0	0	12,710	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):*	(2,951)	0	2,951	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(2,951)	0	2,951	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(4,454)	(6,010)	6,010	0	0	0	0	0	0	0	0	(4,454)	45

Facility Name & ID Number Taylorville Terrace

0047795

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative	\$ 108,157	Progressive Housing, Inc.	100.00%	\$	\$ (108,157)	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%	3,267	3,267	4
5	V	19 Professional Services		Progressive Housing, Inc.	100.00%	9,903	9,903	5
6	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,720	3,720	6
7	V	21 Clerical and General Office		Progressive Housing, Inc.	100.00%	63,180	63,180	7
8	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	8,610	8,610	8
9	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,275	1,275	9
10	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	724	724	10
11	V	26 Insurance		Progressive Housing, Inc.	100.00%	235	235	11
12	V	30 Depreciation		Progressive Housing, Inc.	100.00%	1,759	1,759	12
13	V	32 Interest		Progressive Housing, Inc.	100.00%	9,395	9,395	13
14	Total		\$ 108,157			\$ 102,147	\$ * (6,010)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	34 Rent		Progressive Housing, Inc.	100.00%	\$ 1,503	\$	1,503	15
16	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	1,556		1,556	16
17	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	2,951		2,951	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		\$			\$ 6,010	\$ *	6,010	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Taylorville Terrace

0047795

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 Taylorville Terrace # 0047795 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 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	9,135	3Hrs/MTG	1.00	Dir. Fees	\$ 465	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,135	3Hrs/MTG	1.00	Dir. Fees	465	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	7,613	3Hrs/MTG	1.00	Dir. Fees	387	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,374	3Hrs/MTG	1.00	Dir. Fees	426	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,135	3Hrs/MTG	1.00	Dir. Fees	465	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,135	3Hrs/MTG	1.00	Dir. Fees	465	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	5,329	3Hrs/MTG	1.00	Dir. Fees	271	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,944		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

Taylorville Terrace
 0047795
 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 Taylorville Terrace

0047795

Report Period Beginning:

7/1/2014

Ending: 3/30/2015

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 NO

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

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	5	Utilities	Budgeted Rev/Dir Cost 13,171,654	33	939		642,780	\$ 45	1
2	6	Maintenance	Budgeted Rev/Dir Cost 13,171,654	33	701		642,780	34	2
3	18	Director Fees	Budgeted Rev/Dir Cost 13,171,654	33	67,447		642,780	3,267	3
4	19	Professional Services	Budgeted Rev/Dir Cost 13,171,654	33	204,232		642,780	9,903	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost 13,171,654	33	74,328		642,780	3,720	5
6	21	Clerical and General Office	Budgeted Rev/Dir Cost 13,171,654	33	1,291,500	1,101,919	642,780	63,180	6
7	22	Employee Benefits	Budgeted Rev/Dir Cost 13,171,654	33	178,040		642,780	8,610	7
8	24	Travel and Seminar	Budgeted Rev/Dir Cost 13,171,654	33	27,459		642,780	1,275	8
9	25	Auto Expense	Budgeted Rev/Dir Cost 13,171,654	33	14,968		642,780	724	9
10	26	Insurance	Budgeted Rev/Dir Cost 13,171,654	33	8,530		642,780	235	10
11	30	Depreciation	Budgeted Rev/Dir Cost 13,171,654	33	36,018		642,780	1,759	11
12	32	Interest	Budgeted Rev/Dir Cost 13,171,654	33	238,933		642,780	9,395	12
13	34	Rent	Budgeted Rev/Dir Cost 13,171,654	33	31,050		642,780	1,503	13
14	35	Equipment Rental	Budgeted Rev/Dir Cost 13,171,654	33	40,919		642,780	1,556	14
15	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost 13,171,654	33	281,423		642,780	2,951	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		\$ 108,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Taylorville Terrace

0047795

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 950,598	\$ 768,373	08/15/26	6.7500	\$ 37,606						
2																	
3																	
4																	
5																	
Working Capital																	
6	Amortization										1,362						
7	Allocation from Home Office-Interest										11,398						
8	Allocation from Home Office-Amortization										598						
9	TOTAL Facility Related						\$ 950,598	\$ 768,373			\$ 50,964						
B. Non-Facility Related*																	
10																	
11																	
12									Interest Income Offset		(2,601)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,601)						
15	TOTALS (line 9+line14)						\$ 950,598	\$ 768,373			\$ 48,363						

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.)

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	FOR BHF USE ONLY	
	2011	_____	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13
	2012	_____	10	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14
	2013	_____	11	15	LESS REFUND FROM LINE 6 \$ _____ 15
	2014	_____	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
N/A - Not for profit entity.					

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 Taylorville Terrace COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0047795

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 Taylorville Terrace

0047795 Report Period Beginning:

7/1/2014 Ending:

6/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300 B. General Construction Type: Exterior Brick/Wood Siding Frame Wood Number of Stories One

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>14,000</u>	<u>1999</u>	<u>\$ 20,000</u>	<u>1</u>
2	<u>Allocated from Home Office</u>			<u>5,631</u>	<u>2</u>
3	TOTALS	14,000		\$ 25,631	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Terrace

0047795

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	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 294,090
5				(12,045)	(301)		(301)		(3,714)
6									
7									
8									
Improvement Type**									
9	Trash and Baffles		1998	2,435		15			2,435
10	Carpeting		2005	2,067	138	15	138		1,321
11	Bathroom Remodel		2007	4,867	324	15	324		2,750
12	Bathroom Remodel		2008	3,024	202	15	202		1,507
13	Fire Alarm Upgrade		2008	1,875	125	15	125		886
14	Concrete Sidewalk		2008	2,220	148	15	148		987
15	Plumbing Improvements to Water Heater		2010	516	34	15	34		182
16	New Air Conditioner - Women's wing		2010	4,336	289	15	289		1,481
17	New Roof (Gross of Write off of Old Roof-See Line 5)		2012	16,660	1,111	15	1,111		3,185
18	New Condenser and Coil - Air Conditioner		2013	3,400	226	15	226		434
19	Replaced 10 Smoke detectors/1 pull station		2015	685	23	15	23		23
20									
21									
22									
23									
24									
25									
26									
27									
28									
29	Allocation from Home Office			20,185			476	476	1,210
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Terrace

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 780,225	\$ 20,569		\$ 21,045	\$ 476	\$ 306,777	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 26,506	\$ 2,676	\$ 2,676	\$	5-10Yrs	\$ 11,329	71
72	Current Year Purchases	3,558	167	167		10 Yrs	167	72
73	Fully Depreciated Assets	17,830				5-10Yrs	17,830	73
74	Allocated from Home Office	17,636		973	973		12,392	74
75	TOTALS	\$ 65,530	\$ 2,843	\$ 3,816	\$ 973		\$ 41,718	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 Dodge Caravan/2005 Ford 1	2004/2005	\$ 35,558	\$	\$	\$	5	\$ 35,558	76
77	Resident Transportation	Capitalized Repairs	2008	2,403				5	2,403	77
78	Resident Transportation	Capitalized Repairs	2014	2,183	342	342		5	359	78
79	Allocated from Home Office			7,366		310	310	5	6,465	79
80	TOTALS			\$ 47,510	\$ 342	\$ 652	\$ 310		\$ 44,785	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)	\$ 918,896	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,754	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,513	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,759	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 393,280	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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			1,503			5
6		Rental income offset			(1,503)			6
7	TOTAL				\$			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 1,556 Description: Allocated from Home Office - postage machine \$76, copier \$1028, storage \$452

(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 Taylorville Terrace # 0047795 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.)

<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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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				1,862		1,862	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			\$		\$	\$ 1,862		\$ 1,862	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

Facility Name & ID Number Taylorville Terrace # 0047795 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	\$ 37,928	\$ 37,928	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>19,452</u>)	35,887	35,887	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,572	2,572	7
8	Accounts Receivable (owners or related parties)	82,225	82,225	8
9	Other(specify): <u>Reserves/Deposits</u>	94,739	94,739	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 253,351	\$ 253,351	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	25,631	13
14	Buildings, at Historical Cost	763,260	780,225	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	84,818	113,040	16
17	Accumulated Depreciation (book methods)	(377,646)	(393,280)	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>)	6,152	6,152	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 496,584	\$ 531,768	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 749,935	\$ 785,119	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 10,848	\$ 10,848	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,648	18,648	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,284	3,284	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	13,265	13,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	8,476	8,476	36
37	<u>Deposits/Deferred Income</u>	1,111	1,111	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 55,632	\$ 55,632	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	768,373	768,373	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)	\$ 768,373	\$ 768,373	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 824,005	\$ 824,005	46
47	TOTAL EQUITY(page 18, line 24)	\$ (74,070)	\$ (38,886)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 749,935	\$ 785,119	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (100,310)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (100,310)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,240	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)	\$ 26,240	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)	\$ (74,070)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 595,254	1	
2	Discounts and Allowances for all Levels		2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 595,254	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	4,649	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,649	23	
D. Non-Operating Revenue				
24	Contributions	3,052	24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,052	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>Rental Income</u>	2,477	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,477	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 605,432	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	72,781	31	
32	Health Care	193,122	32	
33	General Administration	210,276	33	
B. Capital Expense				
34	Ownership	62,722	34	
C. Ancillary Expense				
35	Special Cost Centers	1,862	35	
36	Provider Participation Fee	38,429	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 579,192	40	
41	Income before Income Taxes (line 30 minus line 40)**	26,240	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,240	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 595,254	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)	\$ 595,254	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

Taylorville Terrace
0047795
6/30/2015

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	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	38	1,418	29.54	3
4	Licensed Practical Nurses	840	13,416	13.15	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	2,095	18,205	8.62	15
16	Dishwashers				16
17	Maintenance Workers	479	4,898	8.61	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	291	9,907	31.25	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	63	2,507	38.57	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	29	548	14.42	28
29	Resident Services Coordinator	1,949	27,778	13.12	29
30	Habilitation Aides (DD Homes)	13,075	123,262	8.85	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,859	201,939 *	9.99	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	26	\$ 1,412	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	126	3,196	L10, C3	38
39	Pharmacist Consultant	Monthly	1,045	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	1,604	L12, C3	45
46	Other(specify) <u>Dental</u>	4	300	L10, C3	46
47	<u>Psychological</u>	1	10	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	186	\$ 12,367		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

SEE ACCOUNTANTS' COMPILATION REPORT

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												
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

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. \$ 3,354 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. \$ 38,429
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. \$ 4,538 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.