

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0040352

Facility Name: Terra Estates

Address: 620 North Main Street Hoyleton 62803
Number City Zip Code

County: Washington

Telephone Number: (217) 493-6373 Fax # (217) 493-7514

HFS ID Number:

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

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C (3)

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Tracey Pelozza Telephone Number: (708) 283-1530
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 07/01/2011 to 06/30/2012 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) Jerry Johnson
(Title) Controller

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Larry Templin
Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
PO 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

Facility Name & ID Number Terra Estates# 0040352 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 bedsN/A

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	<u>4,737</u>			<u>4,737</u>	13
14	TOTALS	<u>4,737</u>			<u>4,737</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.11%

D. How many bed-hold days during this year were paid by the Department?

53 (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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

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

YES ☐NO ☒

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

Date started 05/01/1993

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

YES ☒Date 04/30/1993NO ☐

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

YES ☐NO ☒If YES, enter number
of beds certified 0 and days of care provided 0Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

	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	5,058	1,773	1,826	8,657		8,657		8,657		1
2	Food Purchase		35,994		35,994		35,994	(9)	35,985		2
3	Housekeeping		4,377		4,377		4,377	4	4,381		3
4	Laundry		2,528		2,528		2,528		2,528		4
5	Heat and Other Utilities			15,966	15,966		15,966	759	16,725		5
6	Maintenance	14,768	3,020	8,575	26,363		26,363	833	27,196		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	19,826	47,692	26,367	93,885		93,885	1,587	95,472		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	301,415	7,863	840	310,118		310,118		310,118		10
10a	Therapy			2,392	2,392		2,392		2,392		10a
11	Activities		877	649	1,526		1,526		1,526		11
12	Social Services			1,605	1,605		1,605		1,605		12
13	CNA Training										13
14	Program Transportation			5,728	5,728		5,728		5,728		14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	301,415	8,740	11,214	321,369		321,369		321,369		16
	C. General Administration										
17	Administrative	12,523		102,020	114,543		114,543	(102,020)	12,523		17
18	Directors Fees							2,626	2,626		18
19	Professional Services			1,210	1,210		1,210	11,082	12,292		19
20	Dues, Fees, Subscriptions & Promotions			1,304	1,304		1,304	1,124	2,428		20
21	Clerical & General Office Expenses	125	3,822	8,546	12,493		12,493	56,429	68,922		21
22	Employee Benefits & Payroll Taxes			78,478	78,478		78,478	8,233	86,711		22
23	Inservice Training & Education			81	81		81		81		23
24	Travel and Seminar			328	328		328	1,813	2,141		24
25	Other Admin. Staff Transportation			63	63		63	1,342	1,405		25
26	Insurance-Prop.Liab.Malpractice			4,552	4,552		4,552	1,110	5,662		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	12,648	3,822	196,582	213,052		213,052	(18,261)	194,791		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	333,889	60,254	234,163	628,306		628,306	(16,674)	611,632		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			17,635	17,635		17,635	(5,071)	12,564			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,355	33,355		33,355	17,270	50,625			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,019	5,019			34
35	Rent-Equipment & Vehicles							607	607			35
36	Other (specify):*											36
37	TOTAL Ownership			50,990	50,990		50,990	17,825	68,815			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,742	605	4,347		4,347		4,347			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,415	40,415		40,415		40,415			42
43	Other (specify):* Non-allowable Costs											43
44	TOTAL Special Cost Centers		3,742	41,020	44,762		44,762		44,762			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	333,889	63,996	326,173	724,058		724,058	1,151	725,209			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,465)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	8,300	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(496)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	812			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,151		\$	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))	\$ 1,151		37

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

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

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

Terra Estates

ID#

0040352

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Expensing capitalized repair	\$ 812	25	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	812		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Terra Estates # 0040352 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	(9)	0	0	0	0	0	0	0	0	0	(9)	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	759	0	0	0	0	0	0	0	0	0	759	5
6	Maintenance	0	833	0	0	0	0	0	0	0	0	0	833	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,587	0	0	0	0	0	0	0	0	0	1,587	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	(102,020)	0	0	0	0	0	0	0	0	0	(102,020)	17
18	Directors Fees	0	2,626	0	0	0	0	0	0	0	0	0	2,626	18
19	Professional Services	0	11,082	0	0	0	0	0	0	0	0	0	11,082	19
20	Fees, Subscriptions & Promotions	0	1,124	0	0	0	0	0	0	0	0	0	1,124	20
21	Clerical & General Office Expenses	0	56,429	0	0	0	0	0	0	0	0	0	56,429	21
22	Employee Benefits & Payroll Taxes	0	8,233	0	0	0	0	0	0	0	0	0	8,233	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,813	0	0	0	0	0	0	0	0	0	1,813	24
25	Other Admin. Staff Transportation	812	530	0	0	0	0	0	0	0	0	0	1,342	25
26	Insurance-Prop.Liab.Malpractice	0	1,110	0	0	0	0	0	0	0	0	0	1,110	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	812	(19,073)	0	0	0	0	0	0	0	0	0	(18,261)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	812	(17,486)	0	0	0	0	0	0	0	0	0	(16,674)	29

Summary B

06/30/2012

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$ 9	Progressive Housing, Inc.	100.00%	\$	\$ (9)	1
2	V	3	Housekeeping		Progressive Housing, Inc.	100.00%	4	4	2
3	V	5	Utilities		Progressive Housing, Inc.	100.00%	759	759	3
4	V	6	Maintenance		Progressive Housing, Inc.	100.00%	833	833	4
5	V	17	Administrative	102,020	Progressive Housing, Inc.	100.00%		(102,020)	5
6	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,626	2,626	6
7	V	19	Professional Services		Progressive Housing, Inc.	100.00%	11,082	11,082	7
8	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,124	1,124	8
9	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	56,429	56,429	9
10	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	8,233	8,233	10
11	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,813	1,813	11
12	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	530	530	12
13	V	26	Insurance		Progressive Housing, Inc.	100.00%	1,110	1,110	13
14	Total			\$ 102,029			\$ 84,543	\$ * (17,486)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	\$	Progressive Housing, Inc.	100.00%	\$ 2,394	\$ 2,394	15
16	V	32	Interest	1,621	Progressive Housing, Inc.	100.00%	18,891	17,270	16
17	V	34	Rent		Progressive Housing, Inc.	100.00%	5,019	5,019	17
18	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	607	607	18
19	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	(7,804)	(7,804)	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			\$ 1,621			\$ 19,107	\$ * 17,486	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								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			\$			\$	\$ *	39

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

Facility Name & ID Number

Terra Estates

0040352

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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	9,027	3Hrs/MTG	1.00	Dir. Fees	\$ 573	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,027	3Hrs/MTG	1.00	Dir. Fees	573	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,027	3Hrs/MTG	1.00	Dir. Fees	573	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,027	3Hrs/MTG	1.00	Dir. Fees	573	L18,C8	4
5	Cora Flota	Director	Board Member	None	751	3Hrs/MTG	1.00	Dir. Fees	49	L18,C8	5
6	Edward Copeland	Director	Board Member	None	4,514	3Hrs/MTG	1.00	Dir. Fees	286	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	141,047	1.18	2.95	Salary	8,948	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,574		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

SCHEDULE 7A

Progressive Housing, Inc.

Larry
Manson

175th Place	233	19	116	233	233	233	1,066	3,634
Sauganash	389	33	194	389	389	389	1,783	6,074
Steger	223	19	111	223	223	223	1,022	3,482
Waltonville								

Total PHI	9,600	800	4,800	9,600	9,600	9,600	44,000	149,995
-----------	-------	-----	-------	-------	-------	-------	--------	---------

Facility Name & ID Number Terra Estates# 0040352

Report Period Beginning:

07/01/2011Ending: 6/30/2012

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 ☐

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

Name of Related Organization

Progressive Housing, Inc.

Street Address

3615 Park Drive, Suite 100

City / State / Zip Code

Olympia Fields, IL 60461

Phone Number

(708) 283-1530

Fax Number

(708) 283-2470

	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	3	Housekeeping	Budgeted Rev/Dir Cost	15,472,003	31	\$ 67	\$	923,035	\$ 4	1
2	5	Utilities	Budgeted Rev/Dir Cost	15,472,003	31	12,706		923,035	759	2
3	6	Maintenance	Budgeted Rev/Dir Cost	15,472,003	31	14,679		923,035	833	3
4	18	Director Fees	Budgeted Rev/Dir Cost	15,472,003	31	44,000		923,035	2,626	4
5	19	Professional Services	Budgeted Rev/Dir Cost	15,472,003	31	182,889		923,035	11,082	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	15,472,003	31	15,420		923,035	1,124	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	15,472,003	31	951,030	896,943	923,035	56,429	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	15,472,003	31	138,267		923,035	8,233	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	15,472,003	31	49,382		923,035	1,813	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	15,472,003	31	14,771		923,035	530	10
11	26	Insurance	Budgeted Rev/Dir Cost	15,472,003	31	20,429		923,035	1,110	11
12	30	Depreciation	Budgeted Rev/Dir Cost	15,472,003	31	40,101		923,035	2,394	12
13	32	Interest	Budgeted Rev/Dir Cost	15,472,003	31	316,315		923,035	18,891	13
14	34	Rent	Budgeted Rev/Dir Cost	15,472,003	31	137,366		923,035	5,019	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	15,472,003	31	12,925		923,035	607	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	15,472,003	31	40,910		923,035	(7,804)	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,991,257	\$ 896,943		\$ 103,650	25

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 ☐

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____
Fax Number (_____

	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						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	\$ 803,567	\$ 803,567	08/15/26	6.7500	\$ 32,301	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Amortization										1,054	6	
7	Allocation from Home Office-Interest										18,153	7	
8	Allocation from Home Office-Amortization										738	8	
9	TOTAL Facility Related						\$ 803,567	\$ 803,567			\$ 52,246	9	
	B. Non-Facility Related*												
10												10	
11												11	
12							Interest Income Offset				(1,621)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,621)	14	
15	TOTALS (line 9+line14)						\$ 803,567	\$ 803,567			\$ 50,625	15	

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

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

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

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

B. Real Estate Taxes

[illegible]

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Terra Estates

COUNTY
Washington

FACILITY IDPH LICENSE NUMBER
0040352

CONTACT PERSON REGARDING THIS REPORT
N/A

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,284

B. General Construction Type: Exterior Siding Frame Wood

Number of Stories One

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	40,000	1993	\$ 20,000	1
2	Allocated from Home Office			187	2
3	TOTALS	40,000		\$ 20,187	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1993	1989	\$ 406,000	\$ 10,191	40	\$ 10,191		\$ 194,561
5										
6										
7										
8										
	Improvement Type**									
9	Building Improvements			1995	1,975		15			1,975
10	A.D.A. Shower			1999	2,164	144	15	144		1,947
11	Water Heater			2004	2,099	140	15	140		1,190
12	Bathroom Tile			2004	532	36	15	36		294
13	Kitchen Remodel			2004	1,317	88	15	88		674
14	Kitchen Cabinets			2004	4,346	290	15	290		2,198
15	Kitchen Counter Top			2004	675	45	15	45		341
16	Alarm Strobe Light Fixture			2005	800	53	15	53		377
17	Living Room Carpet			2005	1,105	74	15	74		486
18	Bathroom Remodel			2007	1,042	69	15	69		381
19	Bathroom Remodel			2007	757	50	15	50		251
20	Gazebo			2007	1,796	120	15	120		549
21	Bathroom Remodel			2008	665	44	15	44		195
22	Bathroom Remodel			2008	534	36	15	36		137
23	Building Improvements			2008	1,084	72	15	72		270
24	Replace fire panel			2011	1,145	76	15	76		82
25	Install 6 Sprinkler Heads			2012	1,185	39	15	39		39
26	New Furnace			2012	1,975	44	15	44		44
27										
28										
29										
30										
31	Allocation from Home Office				3,886			2,394	2,394	18,792
32										
33	To offset Building Rent Income							(7,200)	(7,200)	
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

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)		\$ 435,082	\$ 11,611		\$ 6,805	\$ (4,806)	\$ 224,783	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$17,295	\$1,729	\$1,729		5-10Yrs	\$8,593	71
72	Current Year Purchases	1,036	86	86		5-10Yrs	86	72
73	Fully Depreciated Assets	18,786	36	36		5-10Yrs	18,786	73
74	Allocated From Home Office	16,114						74
75	TOTALS	\$53,231	\$1,851	\$1,851			\$27,465	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	2008 Crysler Town Ctry	2004	\$1,209	\$242	\$242		5	\$1,189	76
77	Resident Transportation	2008 Crysler Town Ctry	2007	18,328	3,931	3,666	(265)	5	14,663	77
78										78
79	Allocated from Home Office			7,720						79
80	TOTALS			\$27,257	\$4,173	\$3,908	\$(265)		\$15,852	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$535,757	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$17,635	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$12,564	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(5,071)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$268,100	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Home Office				5,019			6
7	TOTAL				\$ 5,019			7

10. Effective dates of current rental agreement:

Beginning N/A
Ending N/A

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

Fiscal Year EndingAnnual Rent

12. /2013\$ N/A
13. /2014\$ N/A
14. /2015\$ N/A

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

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?
16. Rental Amount for movable equipment: \$ 607 Description: Allocated from Home Office - postage machine, copier
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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		N/A			18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

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.

☐ YES

☒ NO

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

(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.

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	

HFS 3745 (N-4-99)

IL478-2471

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	39(3)	visits			605			605	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				3,742		3,742	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			\$		\$ 605	\$ 3,742		\$ 4,347	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,125	\$ 3,125	1
2	Cash-Patient Deposits	7,201	7,201	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,978)	344,367	344,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,891	1,891	6
7	Other Prepaid Expenses	1,592	1,592	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves</u>	133,093	133,093	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 491,269	\$ 491,269	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,187	20,187	13
14	Buildings, at Historical Cost	435,082	435,082	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	82,013	80,488	16
17	Accumulated Depreciation (book methods)	(268,673)	(268,100)	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>	14,435	14,435	22
23	Other(specify): <u>Deposits</u>	675	675	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 283,719	\$ 282,767	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 774,988	\$ 774,036	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,677	\$ 23,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,201	7,201	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,189	10,189	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	30,189	30,189	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	492	492	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 71,748	\$ 71,748	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	803,567	803,567	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)	\$ 803,567	\$ 803,567	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 875,315	\$ 875,315	46
47	TOTAL EQUITY(page 18, line 24)	\$ (100,327)	\$ (101,279)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 774,988	\$ 774,036	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 641,092	1
2	Restatements (describe):		2
3	Rounding	(7)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 641,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,845)	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)	\$ (61,845)	17
	B. Transfers (Itemize):		
18	Allocation of Progressive Housing, Inc. Balance Sheet		18
19	to individual facilities	(679,567)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (679,567)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (100,327)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Terra Estates# 0040352Report Period Beginning: 07/01/2011Ending: 06/30/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 635,281	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 635,281	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,200	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	5,330	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,530	23
	D. Non-Operating Revenue		
24	Contributions	6	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Prior Period Adjustment	14,396	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,396	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 662,213	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	93,885	31
32	Health Care	321,369	32
33	General Administration	213,052	33
	B. Capital Expense		
34	Ownership	50,990	34
	C. Ancillary Expense		
35	Special Cost Centers	4,347	35
36	Provider Participation Fee	40,415	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 724,058	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,845)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,845)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 635,281	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)	\$ 635,281	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name	Terra Estates
ID#	0040352
FYE	6/30/2012

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.

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	764	796	17,004	21.36	3
4	Licensed Practical Nurses	3,958	4,265	61,425	14.40	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	472	550	5,058	9.20	15
16	Dishwashers					16
17	Maintenance Workers	1,442	1,550	14,768	9.53	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	475	522	12,523	23.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4	6	125	20.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,787	1,913	21,756	11.37	29
30	Habilitation Aides (DD Homes)	21,711	23,410	201,230	8.60	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	30,613	33,012	\$ 333,889 *	\$ 10.11	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	82	\$ 1,826	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	3	75	L10, C3	38
39	Pharmacist Consultant	Monthly	590	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	95	2,182	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	210	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,605	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	\$ 6,488		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Patty Ming	Administrator	0	\$ 12,523	Workers' Compensation Insurance		\$ 11,306	IDPH License Fee	\$	
				Unemployment Compensation Insurance		22,809	Advertising: Employee Recruitment		
				FICA Taxes		25,986	Health Care Worker Background Check		
				Employee Health Insurance		18,183	(Indicate # of checks performed 11)	112	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)							Hiring Expense	98	
(List each licensed administrator separately.)			\$ 12,523	Life Insurance		62	Miscellaneous Dues & Fees	1,094	
B. Administrative - Other				Other Employee Benefits		132			
							Allocation from Home Office	1,124	
Description			Amount				Less: Public Relations Expense	()	
Allocated from Progressive Housing, Inc.			\$ 102,020	Allocated from Home Office		8,233	Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 102,020	TOTAL (agree to Schedule V, line 22, col.8)			\$ 86,711	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Sheakly Payroll Service	Payroll Service		\$ 1,210	N/A			Out-of-State Travel	\$	
							In-State Travel	311	
							Allocation from Home Office	1,768	
							Seminar Expense	17	
							Allocation from Home Office	45	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,210				TOTAL	\$ 2,141	

*** Attach copy of IMRF notifications**

****See instructions.**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

N/A

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5-10 Yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 3,427

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.

\$ 40,415

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

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

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

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?

99

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)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	5,058	1,773	1,826	8,657	0	8,657	0	8,657
2. Food Purchase	0	35,994	0	35,994	0	35,994	-9	35,985
3. Housekeeping	0	4,377	0	4,377	0	4,377	4	4,381
4. Laundry	0	2,528	0	2,528	0	2,528	0	2,528
5. Heat and Other Utilities	0	0	15,966	15,966	0	15,966	759	16,725
6. Maintenance	14,768	3,020	8,575	26,363	0	26,363	833	27,196
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	19,826	47,692	26,367	93,885	0	93,885	1,587	95,472
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	301,415	7,863	840	310,118	0	310,118	0	310,118
10a. Therapy	0	0	2,392	2,392	0	2,392	0	2,392
11. Activities	0	877	649	1,526	0	1,526	0	1,526
12. Social Services	0	0	1,605	1,605	0	1,605	0	1,605
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	5,728	5,728	0	5,728	0	5,728
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	301,415	8,740	11,214	321,369	0	321,369	0	321,369
17. Administrative	12,523	0	102,020	114,543	0	114,543	-102,020	12,523
18. Directors Fees	0	0	0	0	0	0	2,626	2,626
19. Professional Services	0	0	1,210	1,210	0	1,210	11,082	12,292
20. Fees, Subscriptions & Promotion	0	0	1,304	1,304	0	1,304	1,124	2,428
21. Clerical & General Office	125	3,822	8,546	12,493	0	12,493	56,429	68,922
22. Employee Benefits & Payroll	0	0	78,478	78,478	0	78,478	8,233	86,711
23. Inservice Training & Education	0	0	81	81	0	81	0	81
24. Travel and Seminar	0	0	328	328	0	328	1,813	2,141
25. Other Admin. Staff Trans	0	0	63	63	0	63	1,342	1,405
26. Insurance-Prop.Liab.Malpractice	0	0	4,552	4,552	0	4,552	1,110	5,662
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	12,648	3,822	196,582	213,052	0	213,052	-18,261	194,791
29. Total General Administrative	333,889	60,254	234,163	628,306	0	628,306	-16,674	611,632
30. Depreciation	0	0	17,635	17,635	0	17,635	-5,071	12,564
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	33,355	33,355	0	33,355	17,270	50,625
33. Real Estate	0	0	0	0	0	0	0	0

34. Rent - Facility & Grounds	0	0	0	0	0	0	5,019	5,019
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	607	607
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	50,990	50,990	0	50,990	17,825	68,815
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	3,742	605	4,347	0	4,347	0	4,347
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	40,415	40,415	0	40,415	0	40,415
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	3,742	41,020	44,762	0	44,762	0	44,762
45. Grand Total	333,889	63,996	326,173	724,058	0	724,058	1,151	725,209

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	3,125	3,125
2. Cash - Patient Deposits	7,201	7,201
3. Accounts & Notes Recievable	344,367	344,367
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,891	1,891
7. Other Prepaid Expenses	1,592	1,592
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	133,093	133,093
10. Total current assets	491,269	491,269
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,187	20,187
14. Buildings, at Historical Cost	435,082	435,082
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	82,013	80,488
17. Accumulated Depreciation (book methods)	-268,673	-268,100
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	14,435	14,435
23. other (specify):	675	675
24. Total Long-Term Assets	283,719	282,767
25. Total Assets	774,988	774,036
CURRENT LIABILITIES		
26. Accounts Payable	23,677	23,677
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	7,201	7,201
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	10,189	10,189
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	30,189	30,189
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	492	492

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	71,748	71,748
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	803,567	803,567
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	803,567	803,567
46.Total Liabilities	875,315	875,315
47.Total Equity	-100,327	-101,279
48.Total Liabilities and Equity	774,988	774,036

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	635,281
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	635,281
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	7,200
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	5,330
22. Laundry	0
Subtotal - Other Operating Revenue	12,530
24. Contributions	6
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	6
27. Other Revenue (specify):	0
28. Other Revenue (specify):	14,396
Subtotal - Other Revenue	14,396
30. Total Revenue	662,213
31. General Services	93,885
32. Health Care	321,369
33. General Administration	213,052
34. Ownership	50,990

35. Special Cost Centers	4,347
35. Provider Participation Fee	40,415
37. Other	0
40. Total Expenses	724,058
41. Income Before Income Taxes	-61,845
42. Income Taxes	0
43. Net Income or Loss for the Year	-61,845