

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0047795</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Taylorville Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>921 East Market St</u> <u>Taylorville</u> <u>62568</u>																									
Number City Zip Code																									
County: <u>Christian</u>																									
Telephone Number: <u>(217) 287-7787</u> Fax # <u>(217) 287-7743</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Lawrence A. Manson</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Larry Templin</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 9, Dunlap, IL 61525</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Lawrence A. Manson</u>	(Title) <u>Chief Executive Officer</u>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Date) _____	(Print Name <u>Larry Templin</u> and Title) <u>Partner</u>	(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 9, Dunlap, IL 61525</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Lawrence A. Manson</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																								
Paid Preparer	(Date) _____																								
	(Print Name <u>Larry Templin</u> and Title) <u>Partner</u>																								
	(Firm Name <u>Templin Healthcare Accounting Services, LLP</u> & Address) <u>P.O. Box 9, Dunlap, IL 61525</u>																								
	(Telephone) <u>(630) 361-2868</u> Fax # ()																								
Date of Initial License for Current Owners: <u>08/02/1991</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 C (3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 C (3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code <u>501 C (3)</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Larry Templin</u> Telephone Number: <u>630-361-2868</u> Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace

0047795 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	5,856	6
7	16	TOTALS	16	5,856	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	5,331			5,331	13
14	TOTALS	5,331			5,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.03%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace # 0047795 Report Period Beginning: 7/1/2019 Ending: 6/30/2020
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	26,974	1,990	763	29,727		29,727		29,727			1
2	Food Purchase		32,061		32,061		32,061		32,061			2
3	Housekeeping		1,646		1,646		1,646	13	1,659			3
4	Laundry		2,461		2,461		2,461		2,461			4
5	Heat and Other Utilities			13,648	13,648		13,648		13,648			5
6	Maintenance	12,875	6,126	9,937	28,938		28,938	4,545	33,483			6
7	Other (specify):*											7
8	TOTAL General Services	39,849	44,284	24,348	108,481		108,481	4,558	113,039			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	242,457	16,140	851	259,448		259,448		259,448			10
10a	Therapy											10a
11	Activities		4,075	13	4,088		4,088		4,088			11
12	Social Services			1,361	1,361		1,361		1,361			12
13	CNA Training	4,143			4,143		4,143		4,143			13
14	Program Transportation			8,213	8,213		8,213		8,213			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	246,600	20,215	16,438	283,253		283,253		283,253			16
	C. General Administration											
17	Administrative	17,655		114,290	131,945		131,945	(114,290)	17,655			17
18	Directors Fees							4,375	4,375			18
19	Professional Services			8,503	8,503		8,503	6,892	15,395			19
20	Dues, Fees, Subscriptions & Promotions			1,374	1,374		1,374	2,453	3,827			20
21	Clerical & General Office Expenses	8,569	3,895	10,129	22,593		22,593	72,220	94,813			21
22	Employee Benefits & Payroll Taxes			96,155	96,155		96,155	11,403	107,558			22
23	Inservice Training & Education			1,731	1,731		1,731		1,731			23
24	Travel and Seminar			814	814		814	2,067	2,881			24
25	Other Admin. Staff Transportation			3,608	3,608		3,608	1,150	4,758			25
26	Insurance-Prop.Liab.Malpractice			9,544	9,544		9,544	464	10,008			26
27	Other (specify):*											27
28	TOTAL General Administration	26,224	3,895	246,148	276,267		276,267	(13,266)	263,001			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	312,673	68,394	286,934	668,001		668,001	(8,708)	659,293			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			16,412	16,412		16,412	18,485	34,897			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							7,463	7,463			35
36	Other (specify):*											36
37	TOTAL Ownership			16,412	16,412		16,412	25,948	42,360			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,173		2,173		2,173		2,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,049	39,049		39,049		39,049			42
43	Other (specify):* Disallowed Costs											43
44	TOTAL Special Cost Centers		2,173	39,049	41,222		41,222		41,222			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	312,673	70,567	342,395	725,635		725,635	17,240	742,875			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,221	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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(145)	20		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	(28)	19		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	1,192			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,240		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 17,240		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (2,201)	43	1
2	Expense Fixed Asset Additions under \$2,500	4,339	6	2
3	Miscellaneous Income Offset	(5)	21	3
4	Rental Income Offset	(941)	34	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	1,192		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	<u>Housekeeping</u>	\$	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>\$ 13</u>	<u>\$ 13</u>	1
2	V	6	<u>Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>206</u>	<u>206</u>	2
3	V	18	<u>Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>4,375</u>	<u>4,375</u>	3
4	V	19	<u>Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>6,920</u>	<u>6,920</u>	4
5	V	20	<u>Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,598</u>	<u>2,598</u>	5
6	V	21	<u>Clerical and General Office</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>72,225</u>	<u>72,225</u>	6
7	V	22	<u>Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>11,403</u>	<u>11,403</u>	7
8	V	24	<u>Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,067</u>	<u>2,067</u>	8
9	V	25	<u>Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,150</u>	<u>1,150</u>	9
10	V	26	<u>Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>464</u>	<u>464</u>	10
11	V	30	<u>Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,264</u>	<u>2,264</u>	11
12	V	34	<u>Rent</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>941</u>	<u>941</u>	12
13	V	35	<u>Equipment Rental</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>7,463</u>	<u>7,463</u>	13
14	Total			\$			<u>\$ 112,089</u>	<u>\$ * 112,089</u>	14

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

SEE ACCOUNTANTS' PREPARATION 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	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	\$ 2,201	\$ 2,201	15
16	V	17	Administrative	114,290	Progressive Housing, Inc.	100.00%		(114,290)	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			\$ 114,290			\$ 2,201	\$ * (112,089)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Taylorville Terrace

0047795

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace # 0047795 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	8,230	3Hrs/MTG	1.00	Dir. Fees	\$ 570	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,229	3Hrs/MTG	1.00	Dir. Fees	571	L18,C8	3
4	Hal Brown	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	6
7	Eileen Mullin	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	7
8	Julie Lilie	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	8
9	Shawn Jeffers	Director-Partial yr	Board Member	None	1,496	3Hrs/MTG	1.00	Dir. Fees	104	L18,C8	9
10											10
11					Misc Expenses				20		11
12											12
13								TOTAL	\$ 4,375		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' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace# 0047795

Report Period Beginning:

7/1/2019Ending: 5/30/2020

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

20180 Governors Dr., Suite 300

City / State / Zip Code

Olympia Fields, IL 60461

Phone Number

(708) 283-1530

Fax Number

(708) 283-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
	1	3	Housekeeping	Bed Capacity/Specific Alloc.	252	28	\$ 523	\$	16	\$ 13	1
	2	6	Maintenance	Bed Capacity/Specific Alloc.	252	28	4,326		16	206	2
	3	18	Director Fees	Bed Capacity/Specific Alloc.	252	28	67,510		16	4,375	3
	4	19	Professional Services	Bed Capacity/Specific Alloc.	252	28	109,179		16	6,920	4
	5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	252	28	42,077		16	2,598	5
	6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	252	28	1,118,951	935,187	16	72,225	6
	7	22	Employee Benefits	Bed Capacity/Specific Alloc.	252	28	195,610		16	11,403	7
	8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	252	28	33,408		16	2,067	8
	9	25	Auto Expense	Bed Capacity/Specific Alloc.	252	28	18,416		16	1,150	9
	10	26	Insurance	Bed Capacity/Specific Alloc.	252	28	7,288		16	464	10
	11	30	Depreciation	Bed Capacity/Specific Alloc.	252	28	34,937		16	2,264	11
	12	34	Rent	Bed Capacity/Specific Alloc.	252	28	14,823		16	941	12
	13	35	Equipment Rental	Bed Capacity/Specific Alloc.	252	28	45,991		16	7,463	13
	14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	252	28	43,564		16	2,201	14
	15										15
	16										16
	17										17
	18										18
	19										19
	20										20
	21										21
	22										22
	23										23
	24										24
	25	TOTALS				\$ 1,736,603	\$ 935,187		\$ 114,290		25

SEE ACCOUNTANTS' PREPARATION REPORT

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							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
	Working Capital																		
6	Peoples Bank		X	PPP Loan		4/14/20		116,788		116,788			6						
7													7						
8													8						
9	TOTAL Facility Related						\$	116,788	\$	116,788			\$	9					
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$		\$				\$	14					
15	TOTALS (line 9+line14)							\$	116,788	\$	116,788			\$	15				

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

* 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' PREPARATION 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

[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.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Taylorville Terrace COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0047795

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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:

4,300

B. General Construction Type:

Exterior

Brick/Wood Siding

Frame

Wood

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	14,000	1999	\$ 20,000	1
2	Allocated from Home Office			7,369	2
3	TOTALS	14,000		\$ 27,369	3

SEE ACCOUNTANTS' PREPARATION REPORT

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 *	\$	40	\$ 18,250	\$ 18,250	\$ 385,340	4
5					(12,045)		40	(301)	(301)	(5,219)	5
6											6
7											7
8											8
	Improvement Type**										
9	Trash and Baffles			1998	2,435		15			2,435	9
10	Carpeting			2005	2,067		15	138	138	2,011	10
11	Bathroom Remodel			2007	4,867		15	324	324	4,370	11
12	Bathroom Remodel			2008	3,024		15	202	202	2,517	12
13	Fire Alarm Upgrade			2008	1,875		15	125	125	1,511	13
14	Concrete Sidewalk			2008	2,220		15	148	148	1,727	14
15	Plumbing Improvements toWater Heater			2010	516		15	34	34	352	15
16	New Air Conditioner - Women's wing			2010	4,336		15	289	289	2,926	16
17	New Roof (Gross of Write off of Old Roof-See Line 5)			2012	16,660		15	1,111	1,111	8,740	17
18	New Condenser and Coil - Air Conditioner			2013	3,400		15	227	227	1,568	18
19	Replaced 10 Smoke detectors/1 pull station			2015	685		15	46	46	253	19
20	Kitchen and Bathroom #1 & #2 Renovations:			2019	22,705		15	1,514	1,514	1,871	20
21	Baths: New Onyx Shower Systems/Move Water Lines/New Fixtures										21
22	Kitchen: Replace Cabinets and Countertops										22
23	New Vinly Plank Floors - Entry/Living Rm/Activity Rm/1 Bedroom			2019	6,204		15	414	414	586	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

*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' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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			15,479			(15,479)		47
48								48
49								49
50								50
51		14,698			2,264	2,264	26,747	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		\$ 803,647	\$ 15,479		\$ 24,785	\$ 9,306	\$ 437,735	70

SEE ACCOUNTANTS' PREPARATION 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	\$19,501	\$	\$1,950	\$1,950	5-10 Yrs	\$11,883	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	25,581				5-10 Yrs	25,581	73
74	Allocated from Home Office	26,514						74
75	TOTALS	\$71,596	\$	\$1,950	\$1,950		\$37,464	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	2012-Dodge-Grand Caravan	2017	\$11,293	\$	\$2,259	\$2,259	5	\$5,647	76
77	Facility	2016 Nissan Altima	2018	18,833		3,767	3,767	5	7,220	77
78	Facility	2018 Chevy Malibu	2019	21,356		2,136	2,136	5	2,136	78
79	Allocated from Home Office			2,944						79
80	TOTALS			\$54,426	\$	\$8,162	\$8,162		\$15,003	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)	\$957,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$15,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$34,897	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$19,418	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$490,202	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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								6
7	TOTAL				\$			7

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: N/A *

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: \$ 7,463 Description: Allocated from Home Office - Office Equipment
(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	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		4,143		4,143
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,143	\$	\$ 4,143
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,143			

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

\$

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

(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' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				2,173		2,173	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			\$		\$	\$ 2,173		\$ 2,173	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' PREPARATION REPORT

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	\$ 262,072	\$ 262,072	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,073)	133,716	133,716	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,321)	(3,321)	6
7	Other Prepaid Expenses	14,857	14,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	1,566	1,566	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 408,890	\$ 408,890	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,369	13
14	Buildings, at Historical Cost	30,688	803,647	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	103,421	126,022	16
17	Accumulated Depreciation (book methods)	(60,227)	(490,202)	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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 93,882	\$ 466,836	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 502,772	\$ 875,726	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 52,370	\$ 52,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	116,788	116,788	29
30	Accrued Salaries Payable	38,511	38,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,195	2,195	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Advances from DHS</u>	18,822	18,822	36
37	<u>Intercompany Payable</u>	163,221	163,221	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 391,907	\$ 391,907	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 391,907	\$ 391,907	46
47	TOTAL EQUITY (page 18, line 24)	\$ 110,865	\$ 483,819	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 502,772	\$ 875,726	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 69,356	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 69,356	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	41,509	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)	\$ 41,509	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)	\$ 110,865	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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	\$ 757,248	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 757,248	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	4,143	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,143	23
	D. Non-Operating Revenue		
24	Contributions	933	24
25	Interest and Other Investment Income***	965	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,898	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Allocated from Home Office-See Pg 19B</u>	3,855	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,855	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 767,144	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	108,481	31
32	Health Care	283,253	32
33	General Administration	276,267	33
	B. Capital Expense		
34	Ownership	16,412	34
	C. Ancillary Expense		
35	Special Cost Centers	2,173	35
36	Provider Participation Fee	39,049	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 725,635	40
41	Income before Income Taxes (line 30 minus line 40)**	41,509	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 41,509	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 757,248	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)	\$ 757,248	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A 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' PREPARATION REPORT

Taylorville Terrace
0047795
6/30/2020

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.

Taylorville Terrace
0047795
6/30/2020

SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Gain/Loss on Sale of Assets	(3)
Miscellaneous Income	5
Rental Income	3,853
Total Line 28a	3,855

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	992	1,062	24,245	22.83	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,093	2,293	26,974	11.76	15
16	Dishwashers					16
17	Maintenance Workers	665	1,016	12,875	12.67	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	348	448	17,655	39.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	297	316	8,569	27.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,344	2,595	45,222	17.43	29
30	Habilitation Aides (DD Homes)	13,822	14,861	177,133	11.92	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,561	22,591	\$ 312,673 *	\$ 13.84	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	14	\$ 763	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	413	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	1	13	L11, C3	44
45	Social Service Consultant	22	1,361	L12, C3	45
46	Other(specify) Dental	Monthly	438	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	\$ 8,988		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' PREPARATION REPORT

XX. GENERAL INFORMATION:

- | | |
|---|--|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>N/A</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>8,689</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>39,049</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>5,004</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Line 14</u>
d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>Heinold-Banwart, LTD</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|---|--|

SEE ACCOUNTANTS' PREPARATION REPORT