

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0047795

Facility Name: Taylorville Terrace

Address: 921 East Market St Taylorville 62568
Number City Zip Code

County: Christian

Telephone Number: (217) 287-7787 Fax # (217) 287-7743

HFS ID Number:

Date of Initial License for Current Owners: 08/02/1991

Type of Ownership:

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

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2024 to 6/30/2025 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)
(Type or Print Name) Mark Heptinstall
(Title) Chief Financial Officer

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Taylorville Terrace

#

0047795

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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)		0
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6	16	ICF/DD 16 or Less	16	5,840
7	16	TOTALS	16	5,840

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment							
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	
				Medicaid Primary	Medicare Primary				
8	SNF								8
9	SNF/PED								9
10	ICF								10
11	ICF/DD								11
12	SC								12
13	DD 16 OR LESS	4,933							4,933
14	TOTALS	4,933							4,933

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

84.47%

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

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

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

YES NO X

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

Date started 08/02/1991

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

YES X Date 03/08/1999 NO

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

YES NO X If YES, enter certified beds. number of certified beds

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES X NO

Tax Year: 6/30/25 Fiscal Year: 6/30/25

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Taylorville Terrace

0047795

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

Page 3

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	43,964	976	1,602	46,542		46,542		46,542			1
2	Food Purchase		50,813		50,813		50,813		50,813			2
3	Housekeeping		5,495		5,495		5,495		5,495			3
4	Laundry		3,822		3,822		3,822		3,822			4
5	Heat and Other Utilities			17,528	17,528		17,528		17,528			5
6	Maintenance	38,980	13,592	20,330	72,902		72,902	(8,294)	64,608			6
7	Other (specify):*											7
8	TOTAL General Services	82,944	74,698	39,460	197,102		197,102	(8,294)	188,808			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	512,153	16,798	9,959	538,910		538,910		538,910			10
10a	Therapy											10a
11	Activities		3,738		3,738		3,738		3,738			11
12	Social Services	1,471		913	2,384		2,384		2,384			12
13	CNA Training											13
14	Program Transportation			3,291	3,291		3,291		3,291			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	513,624	20,536	19,563	553,723		553,723		553,723			16
	C. General Administration											
17	Administrative	88,978		148,069	237,047		237,047	(148,069)	88,978			17
18	Directors Fees							4,397	4,397			18
19	Professional Services			10,725	10,725		10,725	3,685	14,410			19
20	Dues, Fees, Subscriptions & Promotions			6,192	6,192		6,192	1,237	7,429			20
21	Clerical & General Office Expenses	4,860	548	4,494	9,902		9,902	91,392	101,294			21
22	Employee Benefits & Payroll Taxes			189,683	189,683		189,683	27,802	217,485			22
23	Inservice Training & Education			890	890		890		890			23
24	Travel and Seminar			1,086	1,086		1,086	3,459	4,545			24
25	Other Admin. Staff Transportation			414	414		414	366	780			25
26	Insurance-Prop.Liab.Malpractice			16,835	16,835		16,835	436	17,271			26
27	Other (specify):*											27
28	TOTAL General Administration	93,838	548	378,388	472,774		472,774	(15,295)	457,479			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	690,406	95,782	437,411	1,223,599		1,223,599	(23,589)	1,200,010			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			8,885	8,885		8,885	28,712	37,597			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,705	5,705			34
35	Rent-Equipment & Vehicles							2,749	2,749			35
36	Other (specify):*											36
37	TOTAL Ownership			8,885	8,885		8,885	37,166	46,051			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,026		3,026		3,026		3,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,120	47,120		47,120		47,120			42
43	Other (specify):* Disallowed Costs			17,375	17,375		17,375	(17,375)				43
44	TOTAL Special Cost Centers		3,026	64,495	67,521		67,521	(17,375)	50,146			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	690,406	98,808	510,791	1,300,005		1,300,005	(3,798)	1,296,207			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	23,724	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	(379)	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	(2,067)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,375)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(7,701)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,798)		\$	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))	\$ (3,798)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (253)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallowed HO Costs	(477)	43	3
4	Offset Miscellaneous Income	(43)	21	4
5	Offset Rental Income	(3,445)	34	5
6	Nonallowable Home Office Legal Fees	(177)	19	6
7	Disallow Auto Repair Cost-Should Be For Joshua	(8,294)	6	7
8	Home Office Depreciation Expense	4,988	30	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,701)		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
Progressive Housing, Inc	100	See Pg 6-Supp		See Pg 6-Supp		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	\$	Progressive Housing, Inc.	100.00%	\$ 0	\$	1
2	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,397	4,397	2
3	V	19	Professional Services		Progressive Housing, Inc.	100.00%	5,929	5,929	3
4	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,869	1,869	4
5	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	91,435	91,435	5
6	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	27,802	27,802	6
7	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	3,459	3,459	7
8	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	366	366	8
9	V	26	Insurance		Progressive Housing, Inc.	100.00%	436	436	9
10	V	33	Real Estate Taxes		Progressive Housing, Inc.	100.00%	0		10
11	V	34	Rent-Facility		Progressive Housing, Inc.	100.00%	9,150	9,150	11
12	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,749	2,749	12
13	V								13
14	Total			\$			\$ 147,592	\$ * 147,592	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%	\$ 477	\$ 477	15
16	V	17	Administrative	148,069	Progressive Housing, Inc.	100.00%		(148,069)	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			\$ 148,069			\$ 477	\$ * (147,592)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ownership Listing-1

ID# 0047795

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

First Name	M I	Last Name
-------------------	------------	------------------

First Name	Middle	Last Name	City	State	Percentage	Percentage	Percentage	
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								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								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								70
71								71
72								72
73								73
74								74
75								75

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Briarbrook Place	East Peoria	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Harris Place	East Peoria	Progressive Careers			3
4			Joshua Manor	Hoyleton	& Housing	Country Club Hills	Workshop	4
5			Park Place	Pana	Progressive Careers			5
6			Aviston Terrace	Aviston	& Housing	University Park	Workshop	6
7			Cardinal	Woodlawn				7
8			Western Gardens	MT. Vernon				8
9			Galaxy	Woodlawn				9
10			Bill Goat Hill	MT. Vernon				10
11			Country Club Hill	Country Club Hills				11
12			Lee street	Country Club Hills				12
13			Baker Street	Country Club Hills				13
14			182nd Street	Country Club Hills				14
15			Osage	Park Forest				15
16			Oakwood	Park Forest				16
17			Blair	Park Forest				17
18			Lowell	Hazelcrest				18
19			Marquette	Park Forest				19
20			Huron	Park Forest				20
21			Wilshire	Park Forest				21
22			175th Place	Country Club Hills				22
23			Burnham	University Park				23
24								24
25								25
26								26
27								27
28								28
29								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	9,159	3Hrs/MTG	1.00	Dir. Fees	\$ 441	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	2
3	Hal Brown	Secretary	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	3
4	Cora Flota	Director	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	4
5	Edward Copeland	Director	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	5
6	Eileen Mullin	Director	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	6
7	Julie Lilie	Director	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	7
8	Eugene Dumas	Director	Board Member	None	9,159	3Hrs/MTG	1.00	Dir. Fees	441	L18,C8	8
9											9
10											10
11						Misc Expenses			869		11
12											12
13								TOTAL	\$ 4,397		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

Facility Name & ID Number Taylorville Terrace # 0047795 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among		in Column 6			
1	6	Maintenance	Bed Capacity/Specific Alloc.	226	26	\$ 31	\$	16	\$ 0	1
2	18	Director Fees	Bed Capacity/Specific Alloc.	226	26	95,026		16	4,397	2
3	19	Professional Services	Bed Capacity/Specific Alloc.	226	26	116,014		16	5,929	3
4	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	226	26	41,498		16	1,869	4
5	21	Clerical and General Office	Bed Capacity/Specific Alloc.	226	26	1,831,926	1,130,934	16	91,435	5
6	22	Employee Benefits	Bed Capacity/Specific Alloc.	226	26	480,741		16	27,802	6
7	24	Travel and Seminar	Bed Capacity/Specific Alloc.	226	26	50,649		16	3,459	7
8	25	Auto Expense	Bed Capacity/Specific Alloc.	226	26	7,877		16	366	8
9	26	Insurance	Bed Capacity/Specific Alloc.	226	26	6,309		16	436	9
10	33	Real Estate Taxes	Bed Capacity/Specific Alloc.	226	26	4,897		16	0	10
11	34	Rent-Facility	Bed Capacity/Specific Alloc.	226	26	199,647		16	9,150	11
12	35	Equipment Rental	Bed Capacity/Specific Alloc.	226	26	61,892		16	2,749	12
13	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	226	26	12,736		16	477	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,909,243	\$ 1,130,934		\$ 148,069	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							\$				\$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$				\$	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Terrace COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0047795

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,300B. General Construction Type: Exterior Brick/Wood SidingFrame WoodNumber of Stories One

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

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

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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			7,954	2
3	TOTALS	14,000		\$ 27,954	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	\$ 476,590	4
5					(12,045)		40	(301)	(301)	(6,724)	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			2,067	10
11	Bathroom Remodel			2007	4,867		15			4,867	11
12	Bathroom Remodel			2008	3,024		15			3,024	12
13	Fire Alarm Upgrade			2008	1,875		15			1,875	13
14	Concrete Sidewalk			2008	2,220		15			2,220	14
15	Plumbing Improvements to Water Heater			2010	516		15	28	28	516	15
16	New Air Conditioner - Women's wing			2010	4,336		15	254	254	4,336	16
17	New Roof (Gross of Write off of Old Roof-See Line 5)			2012	16,660		15	1,111	1,111	14,295	17
18	New Condenser and Coil - Air Conditioner			2013	3,400		15	227	227	2,703	18
19	Replaced 10 Smoke detectors/1 pull station			2015	685		15	46	46	483	19
20	Kitchen and Bathroom #1 & #2 Renovations:			2019	22,705		15	1,514	1,514	9,441	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	2,656	23
24	Replace Flooring/Baseboards - Hallways/Bedrooms/Bathrooms			2022	3,913		15	260	260	912	24
25	Install & Replace Facility Sprinkler Heads & Sensors to Code			2022	4,878		15	324	324	1,082	25
26	2 Hallway Bathrooms - New Onyx Shower Base/Walls/Flooring			2022	8,900		15	593	593	1,582	26
27	Install New Flooring in Living Room & Kitchen			2023	3,510		15	234	234	357	27
28	Install New Blinds in Living Room and Bedrooms			2023	3,032		15	202	202	303	28
29	Install Fire Alarm Panel and Replace Annunciator			2023	3,763		15	251	251	376	29
30	Parking Lot - Sealcoat and Patch Potholes			2024	3,600		15	240	240	360	30
31	Repair Sprinkler Leak in Attic			2024	3,051		15	203	203	305	31
32	Flush the Fire Sprinkler System			2024	11,350		15	757	757	1,135	32
33	Repair Damaged Walls in 2 Hall Bathrooms and Replace			2024	7,497		20	375	375	625	33
34	Flooring/Toilets/Shower Inserts/Vanities and Fixtures										34
35	New Flooring-Great Rm/Main Bathroom & Repair Shower Floor/Drain			2024	11,000		15	601	601	601	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

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	Financial Statement Depreciation			8,885			(8,885)		43
44									44
45									45
46									46
47									47
48									48
49									49
50	Allocated from Home Office		41,738					9,747	50
51									51
52	Home Office Depreciation Adjustment					3,116	3,116		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)		\$ 895,181	\$ 8,885		\$ 28,699	\$ 19,814	\$ 538,169	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	\$23,392	\$	\$2,300	\$2,300	5-10 Yrs	\$8,830	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	39,752				5-10 Yrs	39,752	73
74	Home Office Allocation	44,802		1,872	1,872		33,899	74
75	TOTALS	\$107,946	\$	\$4,172	\$4,172		\$82,481	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	\$	\$	\$	5	\$11,293	76
77	Facility	2016 Nissan Altima	2018	15,833				5	15,833	77
78	Facility	2018 Chevy Malibu	2019	21,356		422	422	5	21,356	78
79	Facility	2020 Toyota Camry	2020	21,517		4,304	4,304	5	21,161	79
80	TOTALS			\$69,999	\$	\$4,726	\$4,726		\$69,643	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)	\$1,101,080	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$8,885	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$37,597	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$28,712	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$690,293	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Home Office				9,150			5
6	Income Offset				(3,445)			6
7	TOTAL				\$ 5,705			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.
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?
16. Rental Amount for movable equipment: \$ 2,749
- Description: Allocated from Home Office-Office Equipment
- (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?

☐ 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

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' 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				3,026		3,026	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			\$		\$	\$ 3,026		\$ 3,026	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	\$330,839	\$330,839	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance89,085)	231,507	231,507	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,060	1,060	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	1,704	1,704	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$565,110	\$565,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,954	13
14	Buildings, at Historical Cost	75,998	895,181	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	128,736	177,945	16
17	Accumulated Depreciation (book methods)	(139,323)	(690,293)	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)	\$85,411	\$410,787	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$650,521	\$975,897	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$34,991	\$34,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,326	42,326	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,955	1,955	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				36
37	Intercompany Payable	1,059,990	1,059,990	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$1,139,262	\$1,139,262	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)	\$1,139,262	\$1,139,262	46
47	TOTAL EQUITY(page 18, line 24)	\$(488,741)	\$(163,365)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$650,521	\$975,897	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (223,203)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (223,203)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(265,538)	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)	\$ (265,538)	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)	\$ (488,741)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Taylorville Terrace

0047795

Report Period Beginning: 7/1/2024

Ending:

6/30/2025

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	\$ 1,013,539	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,013,539	3
	B. Ancillary Revenue		
4	Day Care	1,816	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,816	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	509	24
25	Interest and Other Investment Income***	6,007	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,516	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Pg 19B	12,596	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,596	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,034,467	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	197,102	31
32	Health Care	553,723	32
33	General Administration	472,774	33
	B. Capital Expense		
34	Ownership	8,885	34
	C. Ancillary Expense		
35	Special Cost Centers	20,401	35
36	Provider Participation Fee	47,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,300,005	40
41	Income before Income Taxes (line 30 minus line 40)**	(265,538)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (265,538)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,013,539.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,013,539	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name

Facility ID

Period Ending

Taylorville Terrace

0047795

6/30/2025

SCH 19A

Schedule XVII
Page 19

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

Facility Name

Taylorville Terrace

Facility ID

0047795

Period Ending

6/30/2025

SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Miscellaneous Income	43
Rental Income	3,445
Workshop Reimbursement/Disbursements	9,108
Total Line 28a	12,596

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	1,778	1,842	76,073	41.30	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	43	43	1,471	34.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,759	1,987	43,964	22.13	15
16	Dishwashers					16
17	Maintenance Workers	1,771	1,975	38,980	19.74	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,992	1,992	88,978	44.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	135	149	4,860	32.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	119	119	2,968	24.94	28
29	Resident Services Coordinator	2,022	2,080	48,455	23.30	29
30	Habilitation Aides (DD Homes)	17,005	18,155	384,657	21.19	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	26,624	28,342	\$ 690,406 *	\$ 24.36	34

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	Monthly	\$ 1,602	L1, C3	35
36	Medical Director	Monthly	5,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	160	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	913	L12, C3	45
46	Other(specify) Dental	Monthly	9,795	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,870		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

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

** See instructions.

Facility Name & ID Number		Taylorville Terrace		STATE OF ILLINOIS		Report Period Beginning:		7/1/2024		Page 21	
				# 0047795				Ending:		6/30/2025	
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	
Andy Kindernay		Administrator	0	\$ 88,978	Workers' Compensation Insurance		\$ 22,711	IDPH License Fee		\$	
					Unemployment Compensation Insurance		14,050	Advertising: Employee Recruitment			
					FICA Taxes		52,197	Health Care Worker Background Check			
					Employee Health Insurance		78,624	(Indicate # of checks performed 4)		950	
					Employee Meals		7,320	Patient Background Checks		2 500	
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		1,241	
					Life Insurance		1,721	Hiring Expense		2,757	
					Union Dues		9,231	Miscellaneous Licenses & Fees		97	
					Other Employee Benefits		3,829	Miscellaneous Dues & Subs		2,012	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 88,978							
B. Administrative - Other											
Description				Amount							
Allocated from Progressive Housing, Inc.				\$ 148,069	Allocated from Home Office		27,802				
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 217,485				
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 148,069	E. Schedule of Non-Cash Compensation Paid to Owners or Employees						
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
Barbara Weiner		Compliance Consultant		\$ 81				\$	Out-of-State Travel		\$
Tracey Peloza, LTD		Accounting Services		2,651							
Sikich, LLP		Accounting Services		2,691							
Personnel Planners		UC Consultant		202					In-State Travel		1,086
David A Ring & Associates		Land Surveyor		135							
Annette Skafgaard		Accts Receivable Consultant		508							
Neil Gerber		Accounting Services		49							
Wipfli		Accounting Services		45					Seminar Expense		
									Allocated from Home Office		3,459
See Attached		Legal Services		4,363					Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)				\$ 10,725						TOTAL 4,545	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

Yes-DSP
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

Amount

IL HEALTHCARE ASSOCIATION (IHCA)

503

Other, please specify

Inst on Public Policy for People w Disabilti

485

988

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

253

Other, please specify

Inst on Public Policy for People w Disabilti

253

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

756

Other, please specify

Inst on Public Policy for People w Disabilti

485

1,241

Total
- (5)

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

\$

8,795

Line

10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

47,120

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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

\$

7,320

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (12)

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?

100% Line 14

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?

N/A

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

Sikich, LLP

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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.

Yes

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