

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0047787

Facility Name: SPARTA TERRACE

Address: 1501 MELMAR DRIVE SPARTA 62286
 Number City Zip Code

County: RANDOLPH

Telephone Number: 618-443-2122 **Fax #** 618-443-2339

HFS ID Number: 371238076008

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501©3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: ROB KEIME **Telephone Number:** 309-685-0595 EXT. 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2006 to 06/30/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>VINCENT EVERSON</u>	
	(Title) <u>PRESIDENT & CEO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number SPARTA TERRACE# 0047787 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>5,146</u>			<u>5,146</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>5,146</u>			<u>5,146</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.12%

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

96 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. 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

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 06/01/1990

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

YES Date 06/01/1990 NO

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

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

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number SPARTA TERRACE # 0047787 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	22,632	1,763	2,347	26,742		26,742	26,742			1
2	Food Purchase		22,686		22,686		22,686	22,686			2
3	Housekeeping		2,177	54	2,231		2,231	240	2,471		3
4	Laundry		1,963	182	2,145		2,145		2,145		4
5	Heat and Other Utilities			14,024	14,024		14,024	779	14,803		5
6	Maintenance	13,570		5,624	19,194		19,194	467	19,661		6
7	Other (specify):*										7
8	TOTAL General Services	36,202	28,589	22,231	87,022		87,022	1,486	88,508		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	159,465	6,217	12,187	177,869		177,869	(475)	177,394		10
10a	Therapy			670	670		670		670		10a
11	Activities		3,031		3,031		3,031		3,031		11
12	Social Services			3,066	3,066		3,066		3,066		12
13	CNA Training	1,071	35		1,106		1,106		1,106		13
14	Program Transportation			2,255	2,255		2,255		2,255		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	160,536	9,283	19,378	189,197		189,197	(475)	188,722		16
	C. General Administration										
17	Administrative							35,876	35,876		17
18	Directors Fees			2,738	2,738		2,738		2,738		18
19	Professional Services			5,156	5,156		5,156	63	5,219		19
20	Dues, Fees, Subscriptions & Promotions			1,465	1,465		1,465	490	1,955		20
21	Clerical & General Office Expenses		1,421	17,153	18,574		18,574	(2,846)	15,728		21
22	Employee Benefits & Payroll Taxes			22,123	22,123		22,123	7,757	29,880		22
23	Inservice Training & Education			3,454	3,454		3,454	2,151	5,605		23
24	Travel and Seminar							256	256		24
25	Other Admin. Staff Transportation			145	145		145		145		25
26	Insurance-Prop.Liab.Malpractice			9,236	9,236		9,236	1,353	10,589		26
27	Other (specify):*										27
28	TOTAL General Administration		1,421	61,470	62,891		62,891	45,100	107,991		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	196,738	39,293	103,079	339,110		339,110	46,111	385,221		29

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

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

Facility Name & ID Number SPARTA TERRACE #0047787 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,910	12,910	12,910	2,271	15,181				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,467	1,467	1,467	(2,497)	(1,030)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			74,160	74,160	74,160	1,444	75,604				34
35	Rent-Equipment & Vehicles						97	97				35
36	Other (specify):*											36
37	TOTAL Ownership			88,537	88,537	88,537	1,315	89,852				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,300	36,300	36,300		36,300				42
43	Other (specify):*			141,384	141,384	141,384	(141,384)					43
44	TOTAL Special Cost Centers			177,684	177,684	177,684	(141,384)	36,300				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	196,738	39,293	369,300	605,331	605,331	(93,958)	511,373				45

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

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(141,376)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,654)	32		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	(154)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(792)	43		18
19	Entertainment				19
20	Contributions	(500)	10		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,145)	21		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,621)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (153,621)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

SPARTA TERRACE

ID# 0047787
Report Period Beginning: 07/01/2006
Ending: 06/30/2007

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	240	0	0	0	0	0	0	0	0	240	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	779	0	0	0	0	0	0	0	0	779	5
6	Maintenance	0	0	467	0	0	0	0	0	0	0	0	467	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	1,486	0	1,486	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(500)	0	25	0	0	0	0	0	0	0	0	(475)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(500)	0	25	0	(475)	16							
	C. General Administration													
17	Administrative	0	0	35,876	0	0	0	0	0	0	0	0	35,876	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	63	0	0	0	0	0	0	0	0	63	19
20	Fees, Subscriptions & Promotions	0	0	490	0	0	0	0	0	0	0	0	490	20
21	Clerical & General Office Expenses	(8,145)	0	5,299	0	0	0	0	0	0	0	0	(2,846)	21
22	Employee Benefits & Payroll Taxes	0	0	7,757	0	0	0	0	0	0	0	0	7,757	22
23	Inservice Training & Education	0	0	2,151	0	0	0	0	0	0	0	0	2,151	23
24	Travel and Seminar	0	0	256	0	0	0	0	0	0	0	0	256	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,353	0	0	0	0	0	0	0	0	1,353	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,145)	0	53,245	0	45,100	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,645)	0	54,756	0	46,111	29							

STATE OF ILLINOIS

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning:

07/01/2006 Ending:

Summary B

06/30/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	2,271	0	0	0	0	0	0	0	0	2,271	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,808)	0	311	0	0	0	0	0	0	0	0	(2,497)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,444	0	0	0	0	0	0	0	0	1,444	34
35	Rent-Equipment & Vehicles	0	0	97	0	0	0	0	0	0	0	0	97	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,808)	0	4,123	0	1,315	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(142,168)	0	784	0	0	0	0	0	0	0	0	(141,384)	43
44	TOTAL Special Cost Centers	(142,168)	0	784	0	(141,384)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(153,621)	0	59,663	0	(93,958)	45							

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 ATTACHED RELATED PARTY SCHEDULE</u>		<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		
<u>SEE ATTACHED SCHEDULE 7A</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)
<u>1</u>	<u>V</u>	<u>18</u>	<u>BOARD FEES</u>	<u>\$ 2,838</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>\$ 2,838</u>
<u>2</u>	<u>V</u>	<u>19</u>	<u>PROFESSIONAL FEES</u>	<u>5,045</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>5,045</u>
<u>3</u>	<u>V</u>	<u>20</u>	<u>LICENSE, DUES</u>	<u>1</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1</u>
<u>4</u>	<u>V</u>	<u>21</u>	<u>GENERAL OFFICE</u>	<u>1,961</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1,961</u>
<u>5</u>	<u>V</u>	<u>23</u>	<u>INSERVICE TRAVEL</u>	<u>295</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>295</u>
<u>6</u>	<u>V</u>	<u>32</u>	<u>INTEREST</u>	<u>5</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>5</u>
<u>7</u>	<u>V</u>	<u>32</u>	<u>INTEREST INCOME</u>	<u>(2,600)</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>(2,600)</u>
<u>8</u>	<u>V</u>						
<u>9</u>	<u>V</u>						
<u>10</u>	<u>V</u>						
<u>11</u>	<u>V</u>						
<u>12</u>	<u>V</u>						
<u>13</u>	<u>V</u>						
<u>14</u>	Total		\$ 7,545			\$ 7,545	\$ *

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

Facility Name & ID Number

SPARTA TERRACE

0047787

Report Period Beginning:

07/01/2006

Ending: 06/30/2007

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	35,876	\$	35,876	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	63		63	16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	490		490	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	7,757		7,757	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,151		2,151	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	256		256	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,353		1,353	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,271		2,271	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	299		299	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,444		1,444	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	97		97	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	779		779	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	467		467	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	784		784	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	12		12	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	240		240	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	5,299		5,299	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	25		25	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			59,663	\$ *	59,663	39

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

Facility Name & ID Number SPARTA TERRACE # 0047787 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	20	LICENSE DUES	\$ 1	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	\$ 1	\$	15
16	V	19	PROFESSIONAL FEES	111	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	111		16
17	V	21	OFFICE SUPPLIES	27	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	27		17
18	V	32	INTEREST INCOME	(1,078)	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	(1,078)		18
19	V	43	NONALLOWABLE	8	RESIDENTIAL CENTERS 07/01/05 TO 02/28/07	100.00%	8		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			\$ (931)			\$ (931)	\$ *	39

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

Facility Name & ID Number

SPARTA TERRACE

#

0047787

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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	RONALD SCHROEDER	CHAIRMAN	BOARD MEMBE	NONE	10,219	3HRS/MTG	1.00	DIR. FEES	\$ 581	L18, C8	1
2	SHAWN JEFFERS	VICE CHAIRMAN	BOARD MEMBE	NONE	10,218	3HRS/MTG	1.00	DIR. FEES	582	L18, C8	2
3	EDWARD CHILDERS	SECRETARY	BOARD MEMBE	NONE	10,218	3HRS/MTG	1.00	DIR. FEES	582	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	4,541	3HRS/MTG	1.00	DIR. FEES	259	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	4,541	3HRS/MTG	1.00	DIR. FEES	259	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	8,325	3HRS/MTG	1.00	DIR. FEES	475	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,738		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 SPARTA TERRACE

0047787 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	297	18	\$ 50,800	\$	16	\$ 2,838	1
2	19	PROFESSIONAL FEES	297	18	93,649		16	5,045	2
3	20	LICENSE, DUES	297	18	5		16	1	3
4	21	GENERAL OFFICE	297	18	36,417		16	1,961	4
5	23	INSERVICE TRAVEL	297	18	5,485		16	295	5
6	32	INTEREST	297	18	100		16	5	6
7	32	INTEREST INCOME	297	18	(48,268)		16	(2,600)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 138,188	\$		\$ 7,545	25

Facility Name & ID Number SPARTA TERRACE

0047787 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE COST	297	18	\$ 665,960	\$ 665,960	16	\$ 35,876	1
2	19	PROFESSIONAL FEES	297	18	1,173		16	63	2
3	20	DUES, FEES	297	18	9,102		16	490	3
4	22	EMPLOYEE BENEFITS	297	18	143,996		16	7,757	4
5	23	INSERVICE EDUCATION	297	18	39,936		16	2,151	5
6	24	TRAVEL SEMINAR	297	18	4,744		16	256	6
7	26	INSURANCE	297	18	25,108		16	1,353	7
8	30	DEPRECIATION	297	18	42,150		16	2,271	8
9	32	INTEREST	297	18	5,547		16	299	9
10	34	RENT	297	18	26,806		16	1,444	10
11	35	EQUIPMENT RENTAL	297	18	1,795		16	97	11
12	5	UTILITIES	297	18	14,451		16	779	12
13	6	MAINTENANCE	297	18	8,673		16	467	13
14	43	NONALLOWABLE	297	18	14,551		16	784	14
15	32	MISC INCOME	297	18	228		16	12	15
16	3	HOUSEKEEPING	297	18	4,446		16	240	16
17	21	OFFICE	297	18	98,367		16	5,299	17
18	10	NURSING SUPPLIES	297	18	460		16	25	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,107,493	\$ 665,960		\$ 59,663	25

Facility Name & ID Number SPARTA TERRACE

0047787 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

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 RESIDENTIAL CENTERS, INC.
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	20	LICENSE DUES	NUMBER OF BEDS	193	4	\$ 15	\$ 16	\$ 1	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	193	4	1,334	16	111	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	193	4	320	16	27	3
4	32	INTEREST INCOME	NUMBER OF BEDS	193	4	(13,002)	16	(1,078)	4
5	43	NONALLOWABLE	NUMBER OF BEDS	193	4	100	16	8	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$	\$	(931)	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	EFFINGHAM STATE BANK		X	VEHICLE	\$622.29	09/23/03	\$ 20,257	\$	09/30/06	6.6500	\$ 13	1
2	BANTERRA BANK		X	VEHICLE	\$338.08	08/06/04	17,136	8,157	08/06/09	6.7500	690	2
3	BANTERRA BANK		X	VEHICLE	\$583.59	08/02/06	18,660	13,451	08/02/09	7.7500	627	3
4												4
5												5
	Working Capital											
6				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(2,664)	6
7				MISC./PARENT ALLOCATION							304	7
8												8
9	TOTAL Facility Related				\$1,543.96		\$ 56,053	\$ 21,608			\$ (1,030)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 56,053	\$ 21,608			\$ (1,030)	15

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$	#VALUE!	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	#VALUE!	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	_____	8	
	2003	_____	9	
	2004	_____	10	
	2005	_____	11	
	2006	_____	12	
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SPARTA TERRACE COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0047787

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>N/A</u>	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number SPARTA TERRACE

0047787 Report Period Beginning:

07/01/2006 Ending:

06/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior WOOD/SIDING Frame WOOD Number of Stories ONE

C. Does the Operating Entity? (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).

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SECURITY ALARM SYSTEM		1994	2,045	136	15	136		1,840	9
10		CARPET		1995	1,301	87	15	87		1,085	10
11		REPLACEMENT OF WATER LINE		1995	1,550	103	15	103		1,213	11
12		ADDITIONAL WATER LINE		1995	1,001	67	15	67		773	12
13		MIXING VALVE		1998	626	42	15	42		397	13
14		CARPET		1998	1,185	79	15	79		724	14
15		BACKFLOW PREVENTION		1998	1,131	75	15	75		647	15
16		PAINT AND CERAMIC TILE		1999	827	55	15	55		468	16
17		SECIND BACKFLOW PREVENTION		1999	1,165	78	15	78		635	17
18		TILE		1999	3,116	208	15	208		1,576	18
19		SHOWER		1999	1,113	74	15	74		562	19
20		PARKING LOT		2002	2,850	190	15	190		966	20
21		BATHROOM REMODEL		2006	3,022	145	15	145		145	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

*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

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 20,932	\$ 1,339		\$ 1,339	\$	\$ 11,031	70

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

Facility Name & ID Number SPARTA TERRACE # 0047787 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 31,039	\$ 3,323	\$ 3,323	\$	5-10YRS	\$ 11,977	71
72	Current Year Purchases	5,571	476	476		5-10 YRS	476	72
73	Fully Depreciated Assets	4,905	178	178		5-10 YRS	4,905	73
74	ALLOCATED FROM PARENT		2,271	2,271				74
75	TOTALS	\$ 41,515	\$ 6,248	\$ 6,248	\$		\$ 17,358	75

D. Vehicle Depreciation (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 CARE	2004 FORD FREESTAR	2004	\$ 19,386	\$ 3,877	\$ 3,877	\$	5	\$ 11,631	76
77	RESIDENT CARE	2006 FORD FREESTAR	2006	18,585	3,717	3,717		5	3,717	77
78										78
79										79
80	TOTALS			\$ 37,971	\$ 7,594	\$ 7,594	\$		\$ 15,348	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)		\$ 100,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 15,181	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 15,181	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 43,737	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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.

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COMMUNITY LIVING OPTIONS

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:		16	06/01/00	\$ 74,160	5	5	3
4	Additions							4
5		SEE SCH 6A			1,444			5
6								6
7	TOTAL		16		\$ 75,604			7

10. Effective dates of current rental agreement:

Beginning 06/01/05

Ending 05/31/10

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

Fiscal Year Ending Annual Rent

12.	<u>06/30/08</u>	\$ <u>74,160</u>
13.	<u>06/30/09</u>	\$ <u>74,160</u>
14.	<u>06/30/10</u>	\$ <u>74,160</u>

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: _____ *

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: \$ 97

Description: SEE SCH 6A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		35		35
3	Classroom Wages (a)		335		335
4	Clinical Wages (b)		736		736
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,106	\$	\$ 1,106
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,106		

C. CONTRACTUAL INCOME

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

\$ 1,528

D. NUMBER OF CNAs TRAINED

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

- (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.

Facility Name & ID Number SPARTA TERRACE# 0047787 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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

	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		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number SPARTA TERRACE# 0047787Report Period Beginning: 07/01/2006

Ending:

06/30/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/2007

(last day of reporting year)

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	\$ 500	\$	1
2	Cash-Patient Deposits	3,386		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>5,303</u>)	134,216		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67		6
7	Other Prepaid Expenses	16,046		7
8	Accounts Receivable (owners or related parties)	407,377		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 561,592	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	20,932		15
16	Equipment, at Historical Cost	79,486		16
17	Accumulated Depreciation (book methods)	(43,737)		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)	\$ 56,681	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 618,273	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 50,431	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,386		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,656		30
31	Accrued Taxes Payable (excluding real estate taxes)			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				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 64,473	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	21,608		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)	\$ 21,608	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 86,081	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 532,192	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 618,273	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 427,179	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 427,179	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,013	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)	\$ 105,013	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)	\$ 532,192	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 564,286	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 564,286	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	141,376	9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,528	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)	\$ 142,904	23
D. Non-Operating Revenue			
24	Contributions	500	24
25	Interest and Other Investment Income***	2,654	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,154	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 710,344	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	87,022	31
32	Health Care	189,197	32
33	General Administration	62,891	33
B. Capital Expense			
34	Ownership	88,537	34
C. Ancillary Expense			
35	Special Cost Centers	141,384	35
36	Provider Participation Fee	36,300	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 605,331	40
41	Income before Income Taxes (line 30 minus line 40)**	105,013	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 105,013	43

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

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

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

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

Facility Name & ID Number SPARTA TERRACE

0047787

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

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					3
4	Licensed Practical Nurses	451	451	4,804	10.65	4
5	CNAs & Orderlies					5
6	CNA Trainees	128	128	1,071	8.37	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	2,894	3,046	22,632	7.43	15
16	Dishwashers					16
17	Maintenance Workers	1,538	1,589	13,570	8.54	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,119	2,232	28,680	12.85	29
30	Habilitation Aides (DD Homes)	13,960	15,043	125,981	8.37	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,090	22,489	\$ 196,738 *	\$ 8.75	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	28	\$ 2,169	L1, C3	35
36	Medical Director	MONTHLY	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	357	9,416	L10, C3	38
39	Pharmacist Consultant	MONTHLY	600	L10, C3	39
40	Physical Therapy Consultant	4	274	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	355	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	50	3,066	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 17,080		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **SPARTA TERRACE**

0047787

Report Period Beginning: **07/01/2006**

Ending: **06/30/2007**

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	
N/A ALLOCATED FROM CRM			\$	Workers' Compensation Insurance	\$ (8,399)	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,032	Advertising: Employee Recruitment	570	
				FICA Taxes	17,880	Health Care Worker Background Check	190	
				Employee Health Insurance	7,065	(Indicate # of checks performed 19)		
				Employee Meals	4,579	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE	166	
				EMPLOYEE MORAL	2,723	ADMIN LIC/SUBSCRIPTIONS	40	
						MES MEMBERSHIP	175	
TOTAL (agree to Schedule V, line 17, col. 1)			\$			MISCELLANEOUS DUES & FEES	342	
(List each licensed administrator separately.)						IHCA DUES	472	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,955	
Description			Amount					
N/A			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 29,880			
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
JONES DAY	LEGAL		\$ 147	N/A		\$	Out-of-State Travel	
LAWRENCE MANSON	LEGAL		767					
KRIEG, DEVAULT	LEGAL		1,223					
HEINOLD-BANWART	ACCOUNTING		3,000					
HEINOLD-BANWART	ACCOUNTING		63					
SCHULER, ROCHE, ZWIRNER	LEGAL		19					
PERSONNEL PLANNERS, INC UC CONSULTATION								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,219	TOTAL		\$	Seminar Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)							BEST PRACTICES LISLE	
							98	
							COACHING	
							46	
							MISC SEMINARS	
							112	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 256	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SPARTA TERRACE

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$472
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,113 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,300
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,579 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 99
d. Have vehicle usage logs been maintained? ADEQUATE RECORDS ARE 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
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HEINOLD - BANWART, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.