



Facility Name & ID Number SPARTA TERRACE

# 0047787 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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 16

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,710			5,710	13
14	TOTALS	5,710			5,710	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.77%

D. How many bed-hold days during this year were paid by the Department? 82 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number SPARTA TERRACE # 0047787 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

**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
	<b>A. General Services</b>										
1	Dietary	24,495	2,405	2,548	29,448		29,448		29,448		1
2	Food Purchase		24,309		24,309		24,309		24,309		2
3	Housekeeping		2,154		2,154		2,154	255	2,409		3
4	Laundry		3,149		3,149		3,149		3,149		4
5	Heat and Other Utilities			19,455	19,455		19,455	1,128	20,583		5
6	Maintenance	10,653		5,961	16,614		16,614	465	17,079		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	35,148	32,017	27,964	95,129		95,129	1,848	96,977		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	185,752	8,467	3,919	198,138		198,138	(1,930)	196,208		10
10a	Therapy			1,229	1,229		1,229		1,229		10a
11	Activities		1,707		1,707		1,707		1,707		11
12	Social Services			2,031	2,031		2,031		2,031		12
13	CNA Training	5,370	50		5,420		5,420		5,420		13
14	Program Transportation			3,012	3,012		3,012	(1,166)	1,846		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	191,122	10,224	11,391	212,737		212,737	(3,096)	209,641		16
	<b>C. General Administration</b>										
17	Administrative							46,052	46,052		17
18	Directors Fees			2,503	2,503		2,503	(6)	2,497		18
19	Professional Services			5,441	5,441		5,441	(14)	5,427		19
20	Dues, Fees, Subscriptions & Promotions			1,383	1,383		1,383	249	1,632		20
21	Clerical & General Office Expenses		2,522	4,841	7,363		7,363	1,195	8,558		21
22	Employee Benefits & Payroll Taxes			38,497	38,497		38,497	11,208	49,705		22
23	Inservice Training & Education			2,233	2,233		2,233	3,180	5,413		23
24	Travel and Seminar			115	115		115	218	333		24
25	Other Admin. Staff Transportation			934	934		934		934		25
26	Insurance-Prop.Liab.Malpractice			8,833	8,833		8,833	1,414	10,247		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>		2,522	64,780	67,302		67,302	63,496	130,798		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	226,270	44,763	104,135	375,168		375,168	62,248	437,416		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,873	8,873		8,873	2,367	11,240			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			330	330		330	(6,666)	(6,336)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			75,792	75,792		75,792	1,516	77,308			34
35	Rent-Equipment & Vehicles							101	101			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			84,995	84,995		84,995	(2,682)	82,313			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			34,164	34,164		34,164		34,164			42
43	Other (specify):*			168,749	168,749		168,749	(168,749)				43
44	<b>TOTAL Special Cost Centers</b>			202,913	202,913		202,913	(168,749)	34,164			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	226,270	44,763	392,043	663,076		663,076	(109,183)	553,893			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:

07/01/2008

Ending:

06/30/2009

**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	\$ (168,749)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,591)	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	(238)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,166)	14		16
17	Non-Care Related Fees	(1,574)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,728)	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				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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (180,046)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (180,046)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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SPARTA TERRACEID# 0047787Report Period Beginning: 07/01/2008Ending: 06/30/2009

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SPARTA TERRACE# 0047787

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	88	63	21	61	22	255	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	363	317	141	224	83	1,128	5
6	Maintenance	0	0	0	0	0	0	108	83	34	194	46	465	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>559</b>	<b>463</b>	<b>196</b>	<b>479</b>	<b>151</b>	<b>1,848</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,728)	0	0	0	0	0	(492)	229	0	26	35	(1,930)	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	(1,166)	0	0	0	0	0	0	0	0	0	0	(1,166)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,894)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(492)</b>	<b>229</b>	<b>0</b>	<b>26</b>	<b>35</b>	<b>(3,096)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	17,154	12,377	4,100	11,017	1,404	46,052	17
18	Directors Fees	0	0	(2)	0	0	(4)	0	0	0	0	0	(6)	18
19	Professional Services	0	0	0	0	0	(14)	0	0	0	0	0	(14)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	18	58	54	86	33	249	20
21	Clerical & General Office Expenses	0	1	1	0	0	(5)	385	339	76	333	65	1,195	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	2,267	2,473	729	2,164	3,575	11,208	22
23	Inservice Training & Education	0	0	0	0	0	(1)	1,143	686	315	761	276	3,180	23
24	Travel and Seminar	0	0	0	0	0	0	158	22	0	38	0	218	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	0	0	0	0	381	276	90	266	401	1,414	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>1</b>	<b>(1)</b>	<b>0</b>	<b>0</b>	<b>(24)</b>	<b>21,506</b>	<b>16,231</b>	<b>5,364</b>	<b>14,665</b>	<b>5,754</b>	<b>63,496</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,894)</b>	<b>1</b>	<b>(1)</b>	<b>0</b>	<b>0</b>	<b>(24)</b>	<b>21,573</b>	<b>16,923</b>	<b>5,560</b>	<b>15,170</b>	<b>5,940</b>	<b>62,248</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SPARTA TERRACE# 0047787

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	740	601	204	613	209	2,367	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,829)	0	0	0	0	123	89	67	39	61	(216)	(6,666)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	516	380	124	367	129	1,516	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	22	20	20	20	19	101	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,829)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>123</b>	<b>1,367</b>	<b>1,068</b>	<b>387</b>	<b>1,061</b>	<b>141</b>	<b>(2,682)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(170,323)	0	0	0	0	0	565	288	110	481	130	(168,749)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(170,323)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>565</b>	<b>288</b>	<b>110</b>	<b>481</b>	<b>130</b>	<b>(168,749)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(180,046)	1	(1)	0	0	99	23,505	18,279	6,057	16,712	6,211	(109,183)	45

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>18 BOARD FEES</u>	\$ <u>817</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	\$ <u>817</u>		1
2	V	<u>19 PROFESSIONAL FEES</u>	<u>2,145</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>2,145</u>		2
3	V	<u>20 LICENSE, DUES</u>	<u>31</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>31</u>		3
4	V	<u>21 GENERAL OFFICE</u>	<u>649</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>650</u>	1	4
5	V	<u>23 INSERVICE TRAVEL</u>	<u>152</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>152</u>		5
6	V	<u>32 INTEREST</u>	<u>4</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>4</u>		6
7	V	<u>32 INTEREST INCOME</u>		<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>			7
8	V	<u>22 EMPLOYEE BENEFITS</u>	<u>(27)</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>(27)</u>		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>3,771</u>			\$ <u>3,772</u>	\$ *	1 14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	18 BOARD FEES	\$ 607	PROGRESSIVE HOUSING, INC.	100.00%	\$ 605	\$ (2)
16	V	19 PROFESSIONAL FEES	1,722	PROGRESSIVE HOUSING, INC.	100.00%	1,722	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%		
18	V	21 GENERAL OFFICE	741	PROGRESSIVE HOUSING, INC.	100.00%	742	1
19	V	23 INSERVICE TRAVEL	84	PROGRESSIVE HOUSING, INC.	100.00%	84	
20	V	32 INTEREST	7	PROGRESSIVE HOUSING, INC.	100.00%	7	
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%		
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%		
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,161			\$ 3,160	\$ * (1)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	18 BOARD FEES	\$ 170	PROGRESSIVE HOUSING, INC.	100.00%	\$ 170	\$
16	V	19 PROFESSIONAL FEES	188	PROGRESSIVE HOUSING, INC.	100.00%	188	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%		
18	V	21 GENERAL OFFICE	161	PROGRESSIVE HOUSING, INC.	100.00%	161	
19	V	23 INSERVICE TRAVEL	23	PROGRESSIVE HOUSING, INC.	100.00%	23	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%		
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%		
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%		
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 542			\$ 542	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	18 BOARD FEES	\$ 665	PROGRESSIVE HOUSING, INC.	100.00%	\$ 665	\$
16	V	19 PROFESSIONAL FEES	622	PROGRESSIVE HOUSING, INC.	100.00%	622	
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%		
18	V	21 GENERAL OFFICE	529	PROGRESSIVE HOUSING, INC.	100.00%	529	
19	V	23 INSERVICE TRAVEL	90	PROGRESSIVE HOUSING, INC.	100.00%	90	
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%		
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%		
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%		
23	V	6 MAINTNENCE	2	PROGRESSIVE HOUSING, INC.	100.00%	2	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,908			\$ 1,908	\$ *

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	18 BOARD FEES	\$ 244	PROGRESSIVE HOUSING, INC.	100.00%	\$ 240	\$ (4)
16	V	19 PROFESSIONAL FEES	763	PROGRESSIVE HOUSING, INC.	100.00%	749	(14)
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%		
18	V	21 GENERAL OFFICE	261	PROGRESSIVE HOUSING, INC.	100.00%	256	(5)
19	V	23 INSERVICE TRAVEL	56	PROGRESSIVE HOUSING, INC.	100.00%	55	(1)
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%		
21	V	32 INTEREST INCOME	(6,591)	PROGRESSIVE HOUSING, INC.	100.00%	(6,468)	123
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%		
23	V	6 MAINTENCE		PROGRESSIVE HOUSING, INC.	100.00%		
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ (5,267)			\$ (5,168)	\$ * 99

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

Facility Name & ID Number SPARTA TERRACE# 0047787Report Period Beginning: 07/01/2008 Ending: 06/30/2009

## 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.	\$ 17,154	\$ 17,154
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18	18
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,267	2,267
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,143	1,143
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	158	158
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	381	381
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	740	740
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	89	89
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	516	516
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22	22
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	363	363
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	108	108
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	565	565
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	88	88
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	385	385
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(492)	(492)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 23,505	\$ * 23,505

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 12,377	\$ 12,377
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	58	58
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,473	2,473
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	686	686
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22	22
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	276	276
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	601	601
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	67	67
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	380	380
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	317	317
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	83	83
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	288	288
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	63	63
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	339	339
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	229	229
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 18,279	\$ * 18,279

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

Facility Name &amp; ID Number

SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

## 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.	\$ 4,100	\$ 4,100
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	54	54
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	729	729
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	315	315
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	90	90
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	204	204
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	21	21
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	124	124
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	141	141
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	34	34
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	110	110
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18	18
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	21	21
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	76	76
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 6,057	\$ * 6,057

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 11,017	\$ 11,017
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	86	86
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,164	2,164
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	761	761
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	38	38
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	266	266
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	613	613
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	61	61
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	367	367
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	224	224
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	194	194
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	481	481
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	61	61
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	333	333
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	26	26
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 16,712	\$ * 16,712

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

Facility Name & ID Number SPARTA TERRACE# 0047787Report Period Beginning: 07/01/2008 Ending: 06/30/2009

## 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.	\$ 1,404	\$ 1,404
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	33	33
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,575	3,575
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	276	276
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.		
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	401	401
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	209	209
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(106)	(106)
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	129	129
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19	19
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	83	83
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	46	46
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	130	130
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(110)	(110)
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22	22
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	65	65
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	35	35
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 6,211	\$ * 6,211

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

Facility Name &amp; ID Number

SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

## 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	SECRETARY	BOARD MEMBER	NONE	8,709	3HRS/MTG	1.00	DIR. FEES	\$ 491	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBER	NONE	8,708	3HRS/MTG	1.00	DIR. FEES	492	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBER	NONE	8,708	3HRS/MTG	1.00	DIR. FEES	492	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBER	NONE	5,302	3HRS/MTG	1.00	DIR. FEES	298	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBER	NONE	4,546	3HRS/MTG	1.00	DIR. FEES	254	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBER	NONE	8,330	3HRS/MTG	1.00	DIR. FEES	470	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,497		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:

07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	18	BOARD FEES	NUMBER OF BEDS	290	23	\$ 14,800	\$ 16	\$ 817	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	290	23	38,879	16	2,145	2
3	20	LICENSE, DUES	NUMBER OF BEDS	290	23	559	16	31	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	290	23	11,795	16	650	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	290	23	2,758	16	152	5
6	32	INTEREST	NUMBER OF BEDS	290	23	69	16	4	6
7	32	INTEREST INCOME	NUMBER OF BEDS	290	23		16	0	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	290	23	(489)	16	(27)	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					\$ 68,371	\$	\$ 3,772	25

Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	18	BOARD FEES	NUMBER OF BEDS	296	24	\$ 11,200	\$ 16	\$ 605	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	24	31,866	16	1,722	2
3	20	LICENSE, DUES	NUMBER OF BEDS	296	24		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	296	24	13,705	16	742	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	296	24	1,556	16	84	5
6	32	INTEREST	NUMBER OF BEDS	296	24	124	16	7	6
7	32	INTEREST INCOME	NUMBER OF BEDS	296	24		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	24		16		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					\$ 58,451	\$	\$ 3,160	25

Facility Name & ID Number SPARTA TERRACE

# 0047787 Report Period Beginning: 07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	18	BOARD FEES	NUMBER OF BEDS	302	25	\$ 3,200	\$ 16	\$ 170	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	25	3,552	16	188	2
3	20	LICENSE, DUES	NUMBER OF BEDS	302	25		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	302	25	3,050	16	161	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	302	25	427	16	23	5
6	32	INTEREST	NUMBER OF BEDS	302	25		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	302	25		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	25		16		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					\$ 10,229	\$	\$ 542	25

Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	18	BOARD FEES	NUMBER OF BEDS	308	26	\$ 12,800	\$ 16	\$ 665	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	26	11,983	16	622	2
3	20	LICENSE, DUES	NUMBER OF BEDS	308	26		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	308	26	10,190	16	529	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	308	26	1,725	16	90	5
6	32	INTEREST	NUMBER OF BEDS	308	26		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	308	26		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	26		16		8
9	6	MAINTENCE	NUMBER OF BEDS	308	26	35	16	2	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					\$ 36,733	\$	\$ 1,908	25

Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

PROGRESSIVE HOUSING, INC.

Street Address

PO BOX 10528

City / State / Zip Code

PEORIA, IL. 61612

Phone Number

( 309)685-0595

Fax Number

( 309)685-8463

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.

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	NUMBER OF BEDS	320	28	\$ 4,800	\$ 16	\$ 240	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	320	28	14,975	16	749	2
3	20	LICENSE, DUES	NUMBER OF BEDS	320	28		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	320	28	5,123	16	256	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	320	28	1,100	16	55	5
6	32	INTEREST	NUMBER OF BEDS	320	28		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	320	28	(129,357)	16	(6,468)	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	320	28		16		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					\$	\$	(5,168)	25

Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	17	ADMINISTRATIVE COST	290	23	\$ 310,918	\$ 282,903	16	\$ 17,154	1
2	19	PROFESSIONAL FEES	290	23			16		2
3	20	DUES, FEES	290	23	331		16	18	3
4	22	EMPLOYEE BENEFITS	290	23	41,094		16	2,267	4
5	23	INSERVICE EDUCATION	290	23	20,709		16	1,143	5
6	24	TRAVEL SEMINAR	290	23	2,867		16	158	6
7	26	INSURANCE	290	23	6,907		16	381	7
8	30	DEPRECIATION	290	23	13,415		16	740	8
9	32	INTEREST	290	23	1,618		16	89	9
10	34	RENT	290	23	9,361		16	516	10
11	35	EQUIPMENT RENTAL	290	23	391		16	22	11
12	5	UTILITIES	290	23	6,577		16	363	12
13	6	MAINTENANCE	290	23	1,960		16	108	13
14	43	NONALLOWABLE	290	23	10,236		16	565	14
15	32	MISC INCOME	290	23			16		15
16	3	HOUSEKEEPING	290	23	1,603		16	88	16
17	21	OFFICE	290	23	6,966		16	385	17
18	10	NURSING SUPPLIES	290	23	(8,924)		16	(492)	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 426,029	\$ 282,903		\$ 23,505	25

Facility Name & ID Number SPARTA TERRACE

# 0047787 Report Period Beginning: 07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	17	ADMINISTRATIVE COST	296	24	\$ 228,972	\$ 212,123	16	\$ 12,377	1
2	19	PROFESSIONAL FEES	296	24			16		2
3	20	DUES, FEES	296	24	1,066		16	58	3
4	22	EMPLOYEE BENEFITS	296	24	45,747		16	2,473	4
5	23	INSERVICE EDUCATION	296	24	12,691		16	686	5
6	24	TRAVEL SEMINAR	296	24	400		16	22	6
7	26	INSURANCE	296	24	5,114		16	276	7
8	30	DEPRECIATION	296	24	11,118		16	601	8
9	32	INTEREST	296	24	1,232		16	67	9
10	34	RENT	296	24	7,021		16	380	10
11	35	EQUIPMENT RENTAL	296	24	376		16	20	11
12	5	UTILITIES	296	24	5,872		16	317	12
13	6	MAINTENANCE	296	24	1,534		16	83	13
14	43	NONALLOWABLE	296	24	5,332		16	288	14
15	32	MISC INCOME	296	24			16		15
16	3	HOUSEKEEPING	296	24	1,171		16	63	16
17	21	OFFICE	296	24	6,284		16	339	17
18	10	NURSING SUPPLIES	296	24	4,234		16	229	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 338,164	\$ 212,123		\$ 18,279	25

Facility Name & ID Number SPARTA TERRACE

# 0047787 Report Period Beginning: 07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	302	25	\$ 77,392	\$ 70,662	16	\$ 4,100	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	25			16		2
3	20	DUES, FEES	NUMBER OF BEDS	302	25	1,012		16	54	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	25	13,766		16	729	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	302	25	5,953		16	315	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	302	25			16		6
7	26	INSURANCE	NUMBER OF BEDS	302	25	1,705		16	90	7
8	30	DEPRECIATION	NUMBER OF BEDS	302	25	3,859		16	204	8
9	32	INTEREST	NUMBER OF BEDS	302	25	392		16	21	9
10	34	RENT	NUMBER OF BEDS	302	25	2,340		16	124	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	302	25	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	302	25	2,656		16	141	12
13	6	MAINTENANCE	NUMBER OF BEDS	302	25	634		16	34	13
14	43	NONALLOWABLE	NUMBER OF BEDS	302	25	2,070		16	110	14
15	32	MISC INCOME	NUMBER OF BEDS	302	25	336		16	18	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	302	25	390		16	21	16
17	21	OFFICE	NUMBER OF BEDS	302	25	1,448		16	76	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	302	25			16		18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 114,329	\$ 70,662		\$ 6,057	25

Facility Name & ID Number SPARTA TERRACE

# 0047787 Report Period Beginning: 07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	308	26	\$ 212,076	\$ 190,326	16	\$ 11,017	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	26			16		2
3	20	DUES, FEES	NUMBER OF BEDS	308	26	1,649		16	86	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	26	41,666		16	2,164	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	308	26	14,647		16	761	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	308	26	741		16	38	6
7	26	INSURANCE	NUMBER OF BEDS	308	26	5,114		16	266	7
8	30	DEPRECIATION	NUMBER OF BEDS	308	26	11,804		16	613	8
9	32	INTEREST	NUMBER OF BEDS	308	26	1,168		16	61	9
10	34	RENT	NUMBER OF BEDS	308	26	7,071		16	367	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	308	26	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	308	26	4,306		16	224	12
13	6	MAINTENANCE	NUMBER OF BEDS	308	26	3,743		16	194	13
14	43	NONALLOWABLE	NUMBER OF BEDS	308	26	9,257		16	481	14
15	32	MISC INCOME	NUMBER OF BEDS	308	26			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	308	26	1,171		16	61	16
17	21	OFFICE	NUMBER OF BEDS	308	26	6,416		16	333	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	308	26	500		16	26	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 321,705	\$ 190,326		\$ 16,712	25

Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

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 PO BOX 10528  
 City / State / Zip Code PEORIA, IL. 61612  
 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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	320	28	\$ 28,089	\$ 20,688	16	\$ 1,404	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	320	28			16		2
3	20	DUES, FEES	NUMBER OF BEDS	320	28	666		16	33	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	320	28	71,490		16	3,575	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	320	28	5,526		16	276	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	320	28			16		6
7	26	INSURANCE	NUMBER OF BEDS	320	28	8,024		16	401	7
8	30	DEPRECIATION	NUMBER OF BEDS	320	28	4,180		16	209	8
9	32	INTEREST	NUMBER OF BEDS	320	28	(2,115)		16	(106)	9
10	34	RENT	NUMBER OF BEDS	320	28	2,574		16	129	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	320	28	380		16	19	11
12	5	UTILITIES	NUMBER OF BEDS	320	28	1,669		16	83	12
13	6	MAINTENANCE	NUMBER OF BEDS	320	28	917		16	46	13
14	43	NONALLOWABLE	NUMBER OF BEDS	320	28	2,600		16	130	14
15	32	MISC INCOME	NUMBER OF BEDS	320	28	(2,200)		16	(110)	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	320	28	438		16	22	16
17	21	OFFICE	NUMBER OF BEDS	320	28	1,292		16	65	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	320	28	694		16	35	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 124,224	\$ 20,688		\$ 6,211	25

Facility Name & ID Number

SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

**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		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
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	<b>Working Capital</b>																		
6			<b>OFFSET INTERST INCOME/ NONALLOWABLE INT.</b>								(6,347)	6							
7			<b>MISC./PARENT ALLOCATION LINE OF CREDIT</b>								11	7							
8												8							
9	<b>TOTAL Facility Related</b>																		
	<b>B. Non-Facility Related*</b>																		
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>																		
15	<b>TOTALS (line 9+line14)</b>																		
							\$	\$			\$	(6,336)	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.)

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





Facility Name & ID Number SPARTA TERRACE

# 0047787

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

**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).

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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:**

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	SECURITY ALARM SYSTEM	1994		2,045	69	15	69		2045
10	CARPET	1995		1,301	87	15	87		1259
11	REPLACEMENT OF WATER LINE	1995		1,550	103	15	103		1419
12	ADDITIONAL WATER LINE	1995		1,001	67	15	67		907
13	MIXING VALVE	1998		626	42	15	42		480
14	CARPET	1998		1,185	79	15	79		882
15	BACKFLOW PREVENTION	1998		1,131	75	15	75		799
16	PAINT AND CERAMIC TILE	1999		827	55	15	55		579
17	SECIND BACKFLOW PREVENTION	1999		1,165	78	15	78		788
18	TILE	1999		3,116	208	15	208		1991
19	SHOWER	1999		1,113	74	15	74		711
20	PARKING LOT	2002		2,850	190	15	190		1346
21	BATHROOM REMODEL	2006		3,022	201	15	201		548
22	BATHROOM REMODEL	2008		3,110	207	15	207		354
23	HANDRAILS	2008		638	28	15	28		28
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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)	\$ 24,680	\$ 1,563		\$ 1,563	\$	\$ 14,136	70

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

**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	\$ 32,593	\$ 3,540	\$ 3,540	\$	5-10 YRS	\$ 14,564	71
72	Current Year Purchases	840	53	53		10	53	72
73	Fully Depreciated Assets	10,158				5-10 YRS	10,158	73
74	<b>ALLOCATED FROM PARENT</b>		2,367	2,367				74
75	<b>TOTALS</b>	\$ 43,591	\$ 5,960	\$ 5,960	\$		\$ 24,775	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			\$	\$	\$			\$	76
77	RESIDENT CARE	2006 FORD FREESTAR	2006	18,585	3,717	3,717		5	11,151	77
78										78
79										79
80	<b>TOTALS</b>			\$ 18,585	\$ 3,717	\$ 3,717	\$		\$ 11,151	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)	\$ 86,856	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,240	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)	\$ 50,062	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	<b>TOTALS</b>	\$	\$	\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: RFMS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		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:		<u>16</u>	<u>06/01/00</u>	\$ <u>75,792</u>			3
4	Additions							4
5	<u>SCHEDULE 6E-I</u>				<u>1,516</u>			5
6								6
7	TOTAL		<u>16</u>		\$ <u>77,308</u>			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: \_\_\_\_\_\*

**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: \$ 101 Description: POSTAGE MACHINE/CHAIR LIFT/SCH 6E-I

(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. 06/30/10 \$ 69,746

13. /2011 \$ \_\_\_\_\_

14. /2012 \$ \_\_\_\_\_

\* 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		50		50
3	Classroom Wages (a)		1,790		1,790
4	Clinical Wages (b)		3,580		3,580
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 5,420	\$	\$ 5,420
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	5,420		

**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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>5</b>

- (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.

**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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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**

# **0047787**

Report Period Beginning: **07/01/2008**

Ending: **06/30/2009**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **06/30/2009** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 300	\$	1
2	Cash-Patient Deposits	9,972		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>7,303</u> )	183,957		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	101		6
7	Other Prepaid Expenses	15,000		7
8	Accounts Receivable (owners or related parties)	697,789		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 907,119	\$	10
<b>B. Long-Term Assets</b>				
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	24,680		15
16	Equipment, at Historical Cost	62,176		16
17	Accumulated Depreciation (book methods)	(50,062)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 36,794	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 943,913	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 68,500	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,972		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,935		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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 94,407	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 94,407	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 849,506	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 943,913	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>690,507</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>690,507</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>158,999</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>158,999</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>849,506</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number SPARTA TERRACE

# 0047787

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 636,604	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 636,604	3
<b>B. Ancillary Revenue</b>			
4	Day Care	168,749	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 168,749	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,237	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	1,166	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 8,403	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,728	24
25	Interest and Other Investment Income***	6,591	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,319	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 822,075	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	95,129	31
32	Health Care	212,737	32
33	General Administration	67,302	33
<b>B. Capital Expense</b>			
34	Ownership	84,995	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	168,749	35
36	Provider Participation Fee	34,164	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 663,076	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	158,999	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 158,999	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: **07/01/2008**

Ending: **06/30/2009**

**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	605	605	15,119	24.99	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	600	600	5,370	8.95	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	2,606	2,853	24,495	8.59	15
16	Dishwashers					16
17	Maintenance Workers	1,060	1,166	10,653	9.14	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	1,485	1,641	23,383	14.25	29
30	Habilitation Aides (DD Homes)	15,250	16,456	147,250	8.95	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,606	23,321	\$ 226,270 *	\$ 9.70	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	27	\$ 2,234	L1, C3	35
36	Medical Director	MONTHLY	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	MONTHLY	1,251	L10, C3	39
40	Physical Therapy Consultant	8	565	L10A, C3	40
41	Occupational Therapy Consultant	5	308		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	356	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	31	2,031	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	76	\$ 7,945		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<b>N/A ALLOCATED FROM CRM</b>			\$	<b>Workers' Compensation Insurance</b>	\$ <b>9,904</b>	<b>IDPH License Fee</b>	\$	
				<b>Unemployment Compensation Insurance</b>	<b>5,350</b>	<b>Advertising: Employee Recruitment</b>	<b>80</b>	
				<b>FICA Taxes</b>	<b>20,530</b>	<b>Health Care Worker Background Check</b>	<b>180</b>	
				<b>Employee Health Insurance</b>	<b>7,696</b>	(Indicate # of checks performed <b>18</b> )		
				<b>Employee Meals</b>	<b>4,444</b>	<b>Patient Background Checks</b>		
				<b>Illinois Municipal Retirement Fund (IMRF)*</b>		<b>VEHICLE LICENSE</b>	<b>103</b>	
				<b>EMPLOYEE MORAL</b>	<b>1,089</b>	<b>SUBSCRIPTIONS</b>		
				<b>403B RETIREMENT CONTRIB</b>	<b>606</b>	<b>MES MEMBERSHIP</b>	<b>175</b>	
				<b>DRUG TESTS</b>	<b>86</b>	<b>MISCELLANEOUS DUES &amp; FEES</b>	<b>226</b>	
						<b>IHCA DUES</b>	<b>868</b>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$			<b>Less: Public Relations Expense</b>	( )	
<b>(List each licensed administrator separately.)</b>						<b>Non-allowable advertising</b>	( )	
						<b>Yellow page advertising</b>	( )	
<b>B. Administrative - Other</b>						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <b>1,632</b>	
<b>Description</b>			<b>Amount</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>49,705</b>			
<b>ALLOCATED FROM CRM</b>			\$ <b>46,052</b>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <b>46,052</b>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>		<b>G. Schedule of Travel and Seminar**</b>		
<b>(Attach a copy of any management service agreement)</b>				<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>Description</b>	<b>Amount</b>
<b>C. Professional Services</b>	<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>	<b>N/A</b>		\$	<b>Out-of-State Travel</b>	\$
	<b>SCHUYLER ROCHE</b>	<b>LEGAL</b>	\$ <b>439</b>					
	<b>WELLS FARGO</b>	<b>BOND TRUSTEE</b>	<b>156</b>					
	<b>KRIEG, DEVAULT</b>	<b>LEGAL</b>	<b>2,539</b>					
							<b>In-State Travel</b>	
	<b>HEINOLD-BANWART</b>	<b>ACCOUNTING</b>	<b>2,293</b>					
							<b>FOOD SANITATION</b>	
							<b>IHCA CONV/ DD SYMPOSIUM</b>	<b>144</b>
							<b>Seminar Expense</b>	
							<b>BEST PRACTICES LISLE</b>	<b>42</b>
							<b>CPI</b>	<b>56</b>
							<b>MISC SEMINARS</b>	<b>91</b>
							<b>Entertainment Expense</b>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <b>5,427</b>	<b>TOTAL</b>		\$	(agree to Sch. V, line 24, col. 8)	\$ <b>333</b>
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number SPARTA TERRACE

# 0047787

Report Period Beginning: 07/01/2008 Ending: 06/30/2009

**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 \$868
- (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? 5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 986 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. \$ 34,164  
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. \$ 4,444 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? 96  
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.
- (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.