

Facility Name & ID Number Sparta Terrace

0047787 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,288			4,288	13
14	TOTALS	4,288			4,288	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.42%

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

None (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 Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 06/01/1990

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

YES Date 02/24/2011 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number

Sparta Terrace

0047787

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	12,118	1,982	806	14,906		14,906	14,906			1
2	Food Purchase		21,763		21,763		21,763	21,763			2
3	Housekeeping		2,030		2,030		2,030	2,030			3
4	Laundry		1,367		1,367		1,367	1,367			4
5	Heat and Other Utilities			13,178	13,178		13,178	13,178			5
6	Maintenance	7,345	3,290	4,217	14,852		14,852	14,852			6
7	Other (specify):*										7
8	TOTAL General Services	19,463	30,432	18,201	68,096		68,096	68,096			8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200	1,200			9
10	Nursing and Medical Records	181,821	5,133	4,965	191,919		191,919	191,919			10
10a	Therapy			601	601		601	601			10a
11	Activities		829		829		829	829			11
12	Social Services			1,388	1,388		1,388	1,388			12
13	CNA Training										13
14	Program Transportation			4,940	4,940		4,940	4,940			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	181,821	5,962	13,094	200,877		200,877	200,877			16
	C. General Administration										
17	Administrative	18,720		80,925	99,645		99,645	(80,925)	18,720		17
18	Directors Fees							2,262	2,262		18
19	Professional Services			1,342	1,342		1,342	7,688	9,030		19
20	Dues, Fees, Subscriptions & Promotions			1,139	1,139		1,139	4,296	5,435		20
21	Clerical & General Office Expenses	1,783	1,703	6,741	10,227		10,227	42,329	52,556		21
22	Employee Benefits & Payroll Taxes			69,125	69,125		69,125	5,565	74,690		22
23	Inservice Training & Education			87	87		87		87		23
24	Travel and Seminar			1,856	1,856		1,856	1,342	3,198		24
25	Other Admin. Staff Transportation			2,949	2,949		2,949	548	3,497		25
26	Insurance-Prop.Liab.Malpractice			6,252	6,252		6,252	82	6,334		26
27	Other (specify):*										27
28	TOTAL General Administration	20,503	1,703	170,416	192,622		192,622	(16,813)	175,809		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	221,787	38,097	201,711	461,595		461,595	(16,813)	444,782		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:

7/1/2013

Ending:

6/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			17,940	17,940	17,940	1,137	19,077				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,379	39,379	39,379	8,699	48,078				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						4,896	4,896				34
35	Rent-Equipment & Vehicles						1,191	1,191				35
36	Other (specify):*											36
37	TOTAL Ownership			57,319	57,319	57,319	15,923	73,242				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		957		957	957		957				39
40	Barber and Beauty Shops			33	33	33		33				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,048	32,048	32,048		32,048				42
43	Other (specify):* Non-allowable Costs											43
44	TOTAL Special Cost Centers		957	32,081	33,038	33,038		33,038				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	221,787	39,054	291,111	551,952	551,952	(890)	551,062				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

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Report Period Beginning: 7/1/2013

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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				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	(34)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(630)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(226)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(13)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (903)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (890)		37

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

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

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

Sparta Terrace

ID# 0047787

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Income against Office Supplies	\$ (13)	21	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		(13)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sparta Terrace# 0047787

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(80,925)	0	0	0	0	0	0	0	0	0	(80,925)	17
18	Directors Fees	0	2,262	0	0	0	0	0	0	0	0	0	2,262	18
19	Professional Services	0	7,688	0	0	0	0	0	0	0	0	0	7,688	19
20	Fees, Subscriptions & Promotions	0	4,296	0	0	0	0	0	0	0	0	0	4,296	20
21	Clerical & General Office Expenses	(13)	42,342	0	0	0	0	0	0	0	0	0	42,329	21
22	Employee Benefits & Payroll Taxes	0	5,565	0	0	0	0	0	0	0	0	0	5,565	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,342	0	0	0	0	0	0	0	0	0	1,342	24
25	Other Admin. Staff Transportation	0	548	0	0	0	0	0	0	0	0	0	548	25
26	Insurance-Prop.Liab.Malpractice	0	82	0	0	0	0	0	0	0	0	0	82	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13)	(16,800)	0	0	0	0	0	0	0	0	0	(16,813)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13)	(16,800)	0	0	0	0	0	0	0	0	0	(16,813)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sparta Terrace# 0047787

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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)	
	D. Ownership													
30	Depreciation	(34)	1,171	0	0	0	0	0	0	0	0	0	1,137	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,699	0	0	0	0	0	0	0	0	8,699	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,896	0	0	0	0	0	0	0	0	4,896	34
35	Rent-Equipment & Vehicles	0	0	1,191	0	0	0	0	0	0	0	0	1,191	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(34)	1,171	14,786	0	15,923	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):*	(856)	0	856	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(856)	0	856	0	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(903)	(15,629)	15,642	0	(890)	45							

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Administrative	\$ 80,925	Progressive Housing, Inc.	100.00%	\$	\$ (80,925)	1
2	V	18 Director Fees		Progressive Housing, Inc.	100.00%	2,262	2,262	2
3	V	19 Professional Services		Progressive Housing, Inc.	100.00%	7,688	7,688	3
4	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	4,296	4,296	4
5	V	21 Clerical and General Office		Progressive Housing, Inc.	100.00%	42,342	42,342	5
6	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	5,565	5,565	6
7	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,342	1,342	7
8	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	548	548	8
9	V	26 Insurance		Progressive Housing, Inc.	100.00%	82	82	9
10	V	30 Depreciation		Progressive Housing, Inc.	100.00%	1,171	1,171	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 80,925			\$ 65,296	\$ * (15,629)	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	32 Interest	\$	Progressive Housing, Inc.	100.00%	\$ 8,699	\$	8,699	15
16	V	34 Rent		Progressive Housing, Inc.	100.00%	4,896		4,896	16
17	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	1,191		1,191	17
18	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	856		856	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 15,642	\$ *	15,642	39

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

Facility Name & ID Number

Sparta Terrace

0047787

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

VII. RELATED PARTIES

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

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,219	3Hrs/MTG	1.00	Dir. Fees	\$ 381	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,452	3Hrs/MTG	1.00	Dir. Fees	348	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,220	3Hrs/MTG	1.00	Dir. Fees	380	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,214	3Hrs/MTG	1.00	Dir. Fees	386	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,228	3Hrs/MTG	1.00	Dir. Fees	372	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,216	3Hrs/MTG	1.00	Dir. Fees	384	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	157,093	1.18	2.95	Salary	4,928	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,179		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

Sparta Terrace
0047787
6/30/2014
SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Edward Childers	Cora Flota	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Misc Exp	Total	Larry Manson
Sparta Terrace	381	372	384	348	380	386	11	2,262	4,928
Ellner Terrace	469	459	473	429	468	476	17	2,791	5,777
Taylorville Terrace	479	469	483	438	478	487	17	2,851	7,907
Aviston Terrace	413	404	417	378	412	419	13	2,456	7,111
Briarbrook Place	481	471	486	440	481	488	16	2,863	7,047
Harris Place	444	434	448	406	443	451	15	2,641	6,894
Joshua Manor	382	374	385	350	407	388	(12)	2,274	4,851
Terra Estates	454	444	457	415	453	460	15	2,698	6,695
Park Place	449	439	452	410	448	455	15	2,668	6,703
Western Gardens	229	234	230	211	228	229	64	1,424	3,739
Galaxy	269	273	268	247	268	276	60	1,662	5,086
Cardinal	195	202	198	180	195	199	57	1,226	3,839
Bill Goat Hill	244	249	242	224	243	243	68	1,513	4,588
Country Club Hill	207	213	210	191	207	211	58	1,298	4,039
Lee Street	259	263	257	238	258	253	74	1,602	4,638
Baker Street	197	203	195	182	197	196	67	1,236	3,849
182nd Street	222	228	220	205	221	225	64	1,384	4,178
Osage	183	190	181	169	183	184	64	1,154	3,616
Oakwood	214	220	212	197	213	222	58	1,337	3,879
Blair	296	300	295	272	306	286	71	1,827	4,760
Lowell	260	264	258	239	259	260	69	1,609	4,831
Marquette	242	247	240	223	241	245	65	1,503	4,644
Cherry	229	234	227	211	228	235	61	1,426	4,266
Luella	222	228	219	205	221	228	60	1,383	5,231
Olivia	307	311	305	282	306	282	96	1,889	3,161
Huron	223	229	226	206	222	234	50	1,390	4,146
Wilshire	262	267	266	241	262	258	69	1,625	4,926
Constance	223	228	226	205	222	231	55	1,390	1,550
175th Place	265	270	264	244	265	263	71	1,643	5,015

Sauganash							0	0	4,256	
Steger	514	502	502	464	502	464	109	3,055	8,939	
Waltonville	186	182	187	166	185	171	31	1,108	3,402	
Mt. Vernon	200	197	187	184	198	195	33	1,193	3,530	
Total PHI	<u>9,600</u>	<u>9,600</u>	<u>9,600</u>	<u>8,800</u>	<u>9,600</u>	<u>9,600</u>	<u>1,581</u>	<u>58,381</u>	58,381	<u>162,021</u>

Facility Name & ID Number Sparta Terrace

0047787

Report Period Beginning:

7/1/2013

Ending: 7/30/2014

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 3615 Park Drive, Suite 100
 City / State / Zip Code Olympia Fields, IL 60461
 Phone Number (708) 283-1530
 Fax Number (708) 283-2470

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	Director Fees	Budgeted Rev/Dir Cost	33	58,381		400,656	\$ 2,262	1
2	19	Professional Services	Budgeted Rev/Dir Cost	33	207,339		400,656	7,688	2
3	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	33	85,685		400,656	4,296	3
4	21	Clerical and General Office	Budgeted Rev/Dir Cost	33	1,086,305	1,000,711	400,656	42,342	4
5	22	Employee Benefits	Budgeted Rev/Dir Cost	33	158,964		400,656	5,565	5
6	24	Travel and Seminar	Budgeted Rev/Dir Cost	33	44,262		400,656	1,342	6
7	25	Auto Expense	Budgeted Rev/Dir Cost	33	9,781		400,656	548	7
8	26	Insurance	Budgeted Rev/Dir Cost	33	2,769		400,656	82	8
9	30	Depreciation	Budgeted Rev/Dir Cost	33	30,745		400,656	1,171	9
10	32	Interest	Budgeted Rev/Dir Cost	33	234,828		400,656	8,699	10
11	34	Rent	Budgeted Rev/Dir Cost	33	117,060		400,656	4,896	11
12	35	Equipment Rental	Budgeted Rev/Dir Cost	33	39,570		400,656	1,191	12
13	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	33	(6,363)		400,656	856	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,069,326	\$ 1,000,711		\$ 80,938	25

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 2013 report.	\$			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).	\$			3
4.	Real Estate Tax accrual used for 2014 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.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2009	_____	8	
		2010	_____	9	
		2011	_____	10	
		2012	_____	11	
		2013	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2013 \$		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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sparta Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0047787

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		TOTALS	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

7/1/2013 Ending:

6/30/2014

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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2011</u>	<u>\$ 25,000</u>	1
2	<u>Allocated from Home Office</u>			<u>95</u>	2
3	TOTALS			\$ 25,095	3

Facility Name & ID Number Sparta Terrace

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2011		\$ 475,000	\$ 11,875	40	\$ 11,875	\$	\$ 40,581	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Security Alarm System	1994		2,045		15			2,045	9
10	Carpet	1995		1,301		15			1,301	10
11	Replacement of Water Line	1995		1,550		15			1,550	11
12	Additional Water Line	1995		1,001		15			1,001	12
13	Mixing Valve	1998		627		15			627	13
14	Carpet	1998		1,185		15			1,185	14
15	Backflow Prevention	1998		1,133	31	15		(31)	1,133	15
16	Paint and Ceramic Tile	1999		826	28	15	27	(1)	826	16
17	Secind Backflow Prevention	1999		1,163	65	15	63	(2)	1,163	17
18	Tile	1999		3,116	208	15	208		3,030	18
19	Shower	1999		1,113	74	15	74		1,081	19
20	Parking Lot	2002		2,850	190	15	190		2,296	20
21	Bathroom Remodel	2006		3,022	201	15	201		1,554	21
22	Bathroom Remodel	2008		3,110	207	15	207		1,389	22
23	Handrails	2008		638	43	15	43		243	23
24	Backflow Repair	2011		677	45	15	45		138	24
25	New Air Conditioner	2011		3,016	201	10	201		653	25
26	New Floor-Bedroom	2011		372	25	15	25		59	26
27	New Furnace	2012		2,385	159	15	159		319	27
28	Air Compressor-Sprinkler System	2012		1,722	115	15	115		211	28
29	Replaced Flooring	2014		1,310	7	15	7		7	29
30										30
31	Allocation from Home Office			1,980			85	85	373	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									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)		\$ 511,142	\$ 13,474		\$ 13,525	\$ 51	\$ 62,765	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 37,283	\$ 3,583	\$ 3,583	\$	5-10Yrs	\$ 27,064	71
72	Current Year Purchases	2,620	81	81		10	81	72
73	Fully Depreciated Assets	11,936				5-10Yrs	11,936	73
74	Allocated from Home Office	8,378		896	896		6,500	74
75	TOTALS	\$ 60,217	\$ 3,664	\$ 4,560	\$ 896		\$ 45,581	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2006 Ford Freestar	2006	\$ 18,585	\$	\$	\$	5	\$ 18,585	76
77	Resident Transportation	Capitalized Repairs	2013/2014	4,479	802	802		5	802	77
78										78
79	Allocated from Home Office			4,540		190	190		3,703	79
80	TOTALS			\$ 27,604	\$ 802	\$ 992	\$ 190		\$ 23,090	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 624,058	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,940	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,077	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,137	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 131,436	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		Allocated from Home Office			4,896			6
7	TOTAL				\$ 4,896			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 1,191 Description: Allocated from Home Office - postage machine, copier, storage

(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.

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 7/1/2013 Ending: 6/30/2014
 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? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				957		957	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$ 957		\$ 957	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: 7/1/2013

Ending:

6/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014

(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	\$ 56,012	\$ 56,012	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>6,088</u>)	30,022	30,022	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,875	3,875	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	58,906	58,906	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 148,815	\$ 148,815	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	25,095	13
14	Buildings, at Historical Cost	509,162	511,142	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	74,903	87,821	16
17	Accumulated Depreciation (book methods)	(119,857)	(131,436)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan Costs</u>	4,697	4,697	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 493,905	\$ 497,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 642,720	\$ 646,134	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 8,560	\$ 8,560	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,372	11,372	30
31	Accrued Taxes Payable (excluding real estate taxes)	968	968	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,663	8,663	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	3,750	3,750	36
37	<u>Deposits/Deferred Income</u>	924	924	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 34,237	\$ 34,237	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	153,341	153,341	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)	\$ 153,341	\$ 153,341	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 187,578	\$ 187,578	46
47	TOTAL EQUITY(page 18, line 24)	\$ 455,142	\$ 458,556	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 642,720	\$ 646,134	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 478,215	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 478,215	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(73,080)	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)	\$ (73,080)	17
B. Transfers (Itemize):			
18	Allocation of Progressive Housing, Inc. Balance Sheet	50,007	18
19	to individual facilities		19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 50,007	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 455,142	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 474,533	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 474,533	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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	4,291	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,291	23
D. Non-Operating Revenue			
24	Contributions	48	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	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)	\$ 478,872	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	68,096	31
32	Health Care	200,877	32
33	General Administration	192,622	33
B. Capital Expense			
34	Ownership	57,319	34
C. Ancillary Expense			
35	Special Cost Centers	990	35
36	Provider Participation Fee	32,048	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 551,952	40
41	Income before Income Taxes (line 30 minus line 40)**	(73,080)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (73,080)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 474,533	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 474,533	49

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

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

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

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

Facility Name Sparta Terrace
ID# 0047787
FYE 6/30/2014

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number **Sparta Terrace**

0047787

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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	504	522	11,302	21.65	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,302	1,345	12,118	9.01	15
16	Dishwashers					16
17	Maintenance Workers	596	679	7,345	10.82	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	708	837	18,720	22.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	64	67	1,783	26.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,960	2,086	32,673	15.66	29
30	Habilitation Aides (DD Homes)	13,820	14,926	137,846	9.24	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,954	20,462	\$ 221,787 *	\$ 10.84	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	15	\$ 806	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	824	L10, C3	39
40	Physical Therapy Consultant	4	245	L10a, C3	40
41	Occupational Therapy Consultant	3	216	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	140	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant	25	1,388	L12, C3	45
46	Other(specify) <u>Dental</u>	15	4,141	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	64	\$ 8,960		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Sparta Terrace# 0047787Report Period Beginning: 7/1/2013Ending: 6/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N/A If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,266 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 N/A 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,048
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. \$ 4,047 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 59
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.