FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0047787

Facility Name: Sparta Terrace

Address: 1501 Melmar (Number) Sparta (City) 62286 (Zip Code)

County: Randolph

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Tracey Peloza **Telephone Number:** (708) 283-1530
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jerry Johnson
(Title) Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525
(Telephone) 630-361-2868 Fax # ( )

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 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	5,486			5,486	13
14	TOTALS	5,486			5,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.94%

D. How many bed-hold days during this year were paid by the Department?
55 (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 [X] 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 [X]

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 [X] Date 02/24/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	20,657	2,392	1,418	24,467		24,467		24,467			1
2	Food Purchase		28,893		28,893		28,893	(8)	28,885			2
3	Housekeeping		2,202		2,202		2,202	4	2,206			3
4	Laundry		1,918		1,918		1,918		1,918			4
5	Heat and Other Utilities			16,414	16,414		16,414	665	17,079			5
6	Maintenance	11,435	2,317	5,311	19,063		19,063	730	19,793			6
7	Other (specify):* Home Off. Ben. All.											7
8	TOTAL General Services	32,092	37,722	23,143	92,957		92,957	1,391	94,348			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	200,452	3,367	3,049	206,868		206,868		206,868			10
10a	Therapy			1,041	1,041		1,041		1,041			10a
11	Activities		1,622	561	2,183		2,183		2,183			11
12	Social Services			1,823	1,823		1,823		1,823			12
13	CNA Training											13
14	Program Transportation			8,015	8,015		8,015		8,015			14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	200,452	4,989	15,689	221,130		221,130		221,130			16
	C. General Administration											
17	Administrative	12,421		100,783	113,204		113,204	(100,783)	12,421			17
18	Directors Fees							2,302	2,302			18
19	Professional Services			1,156	1,156		1,156	12,109	13,265			19
20	Dues, Fees, Subscriptions & Promotions			1,228	1,228		1,228	985	2,213			20
21	Clerical & General Office Expenses	125	4,335	8,582	13,042		13,042	49,969	63,011			21
22	Employee Benefits & Payroll Taxes			54,300	54,300		54,300	7,213	61,513			22
23	Inservice Training & Education			170	170		170		170			23
24	Travel and Seminar			614	614		614	1,872	2,486			24
25	Other Admin. Staff Transportation			55	55		55	492	547			25
26	Insurance-Prop.Liab.Malpractice			6,175	6,175		6,175	973	7,148			26
27	Other (specify):* Home Off. Ben. All.											27
28	TOTAL General Administration	12,546	4,335	173,063	189,944		189,944	(24,868)	165,076			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	245,090	47,046	211,895	504,031		504,031	(23,477)	480,554			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sparta Terrace #0047787 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,491	17,491		17,491	2,097	19,588			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,046	43,046		43,046	15,036	58,082			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,676	4,676			34
35	Rent-Equipment & Vehicles							547	547			35
36	Other (specify):*											36
37	**TOTAL Ownership**			60,537	60,537		60,537	22,356	82,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,094	2,816	5,910		5,910		5,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,993	36,993		36,993		36,993			42
43	Other (specify):* Non-allowable Costs											43
44	**TOTAL Special Cost Centers**		3,094	39,809	42,903		42,903		42,903			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	245,090	50,140	312,241	607,471		607,471	(1,121)	606,350			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: 07/01/2011 Ending: 06/30/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(667)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(416)	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	(38)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,121)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,121)		37

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

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

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

Sparta Terrace

ID# 0047787

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Office Supplie	$ (38)	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**	(38)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sparta Terrace # 0047787 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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	(8)	0	0	0	0	0	0	0	0	0	(8)	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	665	0	0	0	0	0	0	0	0	0	665	5
6	Maintenance	0	730	0	0	0	0	0	0	0	0	0	730	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,391	0	0	0	0	0	0	0	0	0	1,391	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	(100,783)	0	0	0	0	0	0	0	0	0	(100,783)	17
18	Directors Fees	0	2,302	0	0	0	0	0	0	0	0	0	2,302	18
19	Professional Services	0	12,109	0	0	0	0	0	0	0	0	0	12,109	19
20	Fees, Subscriptions & Promotions	0	985	0	0	0	0	0	0	0	0	0	985	20
21	Clerical & General Office Expenses	(38)	50,007	0	0	0	0	0	0	0	0	0	49,969	21
22	Employee Benefits & Payroll Taxes	0	7,213	0	0	0	0	0	0	0	0	0	7,213	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,872	0	0	0	0	0	0	0	0	0	1,872	24
25	Other Admin. Staff Transportation	0	492	0	0	0	0	0	0	0	0	0	492	25
26	Insurance-Prop.Liab.Malpractice	0	973	0	0	0	0	0	0	0	0	0	973	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(38)	(24,830)	0	0	0	0	0	0	0	0	0	(24,868)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38)	(23,439)	0	0	0	0	0	0	0	0	0	(23,477)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sparta Terrace # 0047787 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	2,097	0	0	0	0	0	0	0	0	2,097	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	15,036	0	0	0	0	0	0	0	0	15,036	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,676	0	0	0	0	0	0	0	0	4,676	34
35	Rent-Equipment & Vehicles	0	0	547	0	0	0	0	0	0	0	0	547	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	22,356	0	0	0	0	0	0	0	0	22,356	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):*	(1,083)	0	1,083	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,083)	0	1,083	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,121)	(23,439)	23,439	0	0	0	0	0	0	0	0	(1,121)	45

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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. [X] 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	2	Food	$ 8	Progressive Housing, Inc.	100.00%	$	$ (8)	1
2	V	3	Housekeeping		Progressive Housing, Inc.	100.00%	4	4	2
3	V	5	Utilities		Progressive Housing, Inc.	100.00%	665	665	3
4	V	6	Maintenance		Progressive Housing, Inc.	100.00%	730	730	4
5	V	17	Administrative	100,783	Progressive Housing, Inc.	100.00%		(100,783)	5
6	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,302	2,302	6
7	V	19	Professional Services		Progressive Housing, Inc.	100.00%	12,109	12,109	7
8	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	985	985	8
9	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	50,007	50,007	9
10	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	7,213	7,213	10
11	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,872	1,872	11
12	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	492	492	12
13	V	26	Insurance		Progressive Housing, Inc.	100.00%	973	973	13
14	Total			$ 100,791			$ 77,352	$ * (23,439)	14

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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. [X] 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)	
15	V	30	Depreciation	$	Progressive Housing, Inc.	100.00%	$ 2,097	$ 2,097	15
16	V	32	Interest	1,556	Progressive Housing, Inc.	100.00%	16,592	15,036	16
17	V	34	Rent		Progressive Housing, Inc.	100.00%	4,676	4,676	17
18	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	547	547	18
19	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,083	1,083	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			$ 1,556			$ 24,995	$ * 23,439	39

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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			Ellner Terrace	Evansville				1
2			Taylorville Terrace	Taylorville				2
3			Aviston Terrace	Aviston	Progressive			3
4			Briarbrook Place	East Peoria	Housing, Inc.	Olympia Fields	ICF/DD Provider	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	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: 07/01/2011 Ending: 06/30/2012

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,098	3Hrs/MTG	1.00	Dir. Fees	$ 502	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,098	3Hrs/MTG	1.00	Dir. Fees	502	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,098	3Hrs/MTG	1.00	Dir. Fees	502	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,098	3Hrs/MTG	1.00	Dir. Fees	502	L18,C8	4
5	Cora Flota	Director	Board Member	None	759	3Hrs/MTG	1.00	Dir. Fees	41	L18,C8	5
6	Edward Copeland	Director	Board Member	None	4,549	3Hrs/MTG	1.00	Dir. Fees	251	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	142,145	1.18	2.95	Salary	7,850	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,152		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
6/30/2012

SCHEDULE 7A

BOARD OF DIRECTOR FEES

	Progressive Housing, Inc.							
	Edward Childers	Cora Flota	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	Larry Manson
Sparta Terrace	502	41	251	502	502	502	2,302	7,850
Ellner Terrace	513	42	256	513	513	513	2,350	8,015
Taylorville Terrace	559	47	279	559	559	559	2,561	8,728
Aviston Terrace	563	48	282	563	563	563	2,582	8,798
Briarbrook Place	607	50	303	607	607	607	2,781	9,483
Harris Place	550	45	275	550	550	550	2,521	8,597
Joshua Manor	556	46	278	556	556	556	2,548	8,686
Terra Estates	573	49	286	573	573	573	2,626	8,948
Park Place	511	42	256	511	511	511	2,342	7,984
Western Gardens	198	16	99	198	198	198	905	3,087
Galaxy	232	19	116	232	232	232	1,062	3,622
Cardinal	187	16	94	187	187	187	859	2,928
Bill Goat Hill	227	19	114	227	227	227	1,041	3,548
Country Club Hill	173	14	86	173	173	173	792	2,702
Lee Street	155	13	78	155	155	155	711	2,423
Baker Street	161	13	80	161	161	161	737	2,513
182nd Street	183	15	92	183	183	183	839	2,861
Osage	179	15	90	179	179	179	822	2,803
Oakwood	190	16	95	190	190	190	872	2,974
Blair	189	16	95	189	189	189	869	2,961
Lowell	222	18	111	222	222	222	1,018	3,470
Marquette	214	18	107	214	214	214	980	3,340
Cherry	200	17	100	200	200	200	918	3,127
Luella	200	17	100	200	200	200	915	3,118
Olivia	311	27	156	311	311	311	1,427	4,860
Huron	194	16	97	194	194	194	889	3,030
Wilshire	218	18	109	218	218	218	997	3,400
Constance	189	16	94	189	189	189	865	2,949

175th Place	233	19	116	233	233	233	1,066	3,634
Sauganash								
Steger	389	33	194	389	389	389	1,783	6,074
Waltonville	223	19	111	223	223	223	1,022	3,482
Total PHI	9,600	800	4,800	9,600	9,600	9,600	44,000	149,995

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Budgeted Rev/Dir Cost	15,472,003	31	$ 67	$	809,671	$ 4	1
2	5	Utilities	Budgeted Rev/Dir Cost	15,472,003	31	12,706		809,671	665	2
3	6	Maintenance	Budgeted Rev/Dir Cost	15,472,003	31	14,679		809,671	730	3
4	18	Director Fees	Budgeted Rev/Dir Cost	15,472,003	31	44,000		809,671	2,302	4
5	19	Professional Services	Budgeted Rev/Dir Cost	15,472,003	31	182,889		809,671	12,109	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	15,472,003	31	15,420		809,671	985	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	15,472,003	31	951,030	896,943	809,671	50,007	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	15,472,003	31	138,267		809,671	7,213	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	15,472,003	31	49,382		809,671	1,872	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	15,472,003	31	14,771		809,671	492	10
11	26	Insurance	Budgeted Rev/Dir Cost	15,472,003	31	20,429		809,671	973	11
12	30	Depreciation	Budgeted Rev/Dir Cost	15,472,003	31	40,101		809,671	2,097	12
13	32	Interest	Budgeted Rev/Dir Cost	15,472,003	31	316,315		809,671	16,592	13
14	34	Rent	Budgeted Rev/Dir Cost	15,472,003	31	137,366		809,671	4,676	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	15,472,003	31	12,925		809,671	547	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	15,472,003	31	40,910		809,671	1,083	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,991,257	$ 896,943		$ 102,347	25

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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
Street Address
City / State / Zip Code
Phone Number (
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 295,270	$ 295,270	8/15/26	0.0675	$ 43,020	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										26	6
7	Allocation from Home Office-Interest										15,945	7
8	Allocation from Home Office-Amortization										647	8
9	TOTAL Facility Related						$ 295,270	$ 295,270			$ 59,638	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(1,556)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,556)	14
15	TOTALS (line 9+line14)						$ 295,270	$ 295,270			$ 58,082	15

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

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

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	2011	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

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

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2011	$ 25,000	1
2	Allocated from Home Office			164	2
3	TOTALS			$ 25,164	3

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2011		$ 475,000	$ 11,883	40	$ 11,883	$	$ 16,831	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	42	15	42		606	13
14	Carpet			1998	1,185	79	15	79		1,119	14
15	Backflow Prevention			1998	1,133	75	15	75		1,025	15
16	Paint and Ceramic Tile			1999	826	55	15	55		744	16
17	Secind Backflow Prevention			1999	1,163	78	15	78		1,022	17
18	Tile			1999	3,116	208	15	208		2,614	18
19	Shower			1999	1,113	74	15	74		933	19
20	Parking Lot			2002	2,850	190	15	190		1,916	20
21	Bathroom Remodel			2006	3,022	201	15	201		1,152	21
22	Bathroom Remodel			2008	3,110	207	15	207		975	22
23	Handrails			2008	638	43	15	43		157	23
24	Backflow Repair			2011	677	45	15	45		48	24
25	New Air Conditioner			2011	3,016	201	10	201		251	25
26	New Floor-Bedroom			2011	372	17	15	17		17	26
27	New Furnace			2012	2,385	80	15	80		80	27
28											28
29	Allocation from Home Office				3,405			2,097	2,097	16,463	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 509,535	$ 13,478		$ 15,575	$ 2,097	$ 51,850	70

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 38,327	$ 3,938	$ 3,938	$	5-10Yrs	$ 21,966	71
72	Current Year Purchases	899	30	30		5-10Yrs	30	72
73	Fully Depreciated Assets	9,294	45	45		5-10Yrs	9,294	73
74	Allocated From Home Office	14,116						74
75	TOTALS	$ 62,636	$ 4,013	$ 4,013	$		$ 31,290	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										77
78										78
79	Allocated from Home Office			6,763						79
80	TOTALS			$ 25,348	$	$	$		$ 18,585	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)	$ 622,683	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,491	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,588	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,097	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 101,725	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				4,676			6
7	TOTAL				$ 4,676 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$ N/A
13.	/2014	$ N/A
14.	/2015	$ N/A

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

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

16. Rental Amount for movable equipment: $ 547 Description: Allocated from Home Office - postage machine, copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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	39(3)	visits			2,816			2,816	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				3,094		3,094	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 2,816	$ 3,094		$ 5,910	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.

STATE OF ILLINOIS

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,825	$ 2,825	1
2	Cash-Patient Deposits	3,578	3,578	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,237)	117,015	117,015	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,657	1,657	6
7	Other Prepaid Expenses	170	170	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves	48,905	48,905	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 174,150	$ 174,150	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,164	25,164	13
14	Buildings, at Historical Cost	509,535	509,535	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	87,984	87,984	16
17	Accumulated Depreciation (book methods)	(101,725)	(101,725)	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 (spe Loan Costs	5,304	5,304	22
23	Other(specify): Deposit	592	592	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 526,854	$ 526,854	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 701,004	$ 701,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,986	$ 17,986	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,578	3,578	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,300	7,300	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	25,584	25,584	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	431	431	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 54,879	$ 54,879	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	295,270	295,270	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)**	$ 295,270	$ 295,270	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 350,149	$ 350,149	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 350,855	$ 350,855	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 701,004	$ 701,004	48

***(See instructions.)**

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,138,177	1	
2	Restatements (describe):		2	
3	**Rounding**	1	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,138,178	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	9,815	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)**	$ 9,815	17	
	B. Transfers (Itemize):			
18	**Allocation of Progressive Housing, Inc. Balance Sheet**		18	
19	**to individual facilities**	(797,138)	19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (797,138)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 350,855	24	*

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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 596,793	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 596,793	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	6,987	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,987	23
	D. Non-Operating Revenue		
24	Contributions	856	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 856	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	38	28
28a	Prior Period Adjustment	12,612	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,650	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 617,286	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	92,957	31
32	Health Care	221,130	32
33	General Administration	189,944	33
	B. Capital Expense		
34	Ownership	60,537	34
	C. Ancillary Expense		
35	Special Cost Centers	5,910	35
36	Provider Participation Fee	36,993	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 607,471	40
41	**Income before Income Taxes (line 30 minus line 40)****	9,815	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 9,815	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 596,793	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)	$ 596,793	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 6/30/2012

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: 07/01/2011 Ending: 06/30/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	375	405	8,178	20.19	3
4	Licensed Practical Nurses	5	9	130	14.44	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,157	2,362	20,657	8.75	15
16	Dishwashers					16
17	Maintenance Workers	947	1,144	11,435	10.00	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	475	522	12,421	23.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4	6	125	20.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,699	1,885	28,960	15.36	29
30	Habilitation Aides (DD Homes)	16,397	17,786	163,184	9.17	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,059	24,119	$ 245,090 *	$ 10.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	16	$ 1,418	L1, C3	35
36	Medical Director	Monthly	1,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	91	2,286	L10, C3	38
39	Pharmacist Consultant	Monthly	663	L10, C3	39
40	Physical Therapy Consultant	4	239	L10A, C3	40
41	Occupational Therapy Consultant	6	406	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	396	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	28	1,823	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	151	$ 8,431		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patty Ming	Administrator	0	$ 12,421
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 12,421

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 100,783
TOTAL (agree to Schedule V, line 17, col. 3)	$ 100,783
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakly Payroll Service	Payroll Service	$ 1,156
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,156

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,670
Unemployment Compensation Insurance	16,278
FICA Taxes	19,227
Employee Health Insurance	10,685
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403B Retirement Contribution	154
Life Insurance	26
Other Employee Benefits	260
Allocated from Home Office	7,213
TOTAL (agree to Schedule V, line 22, col.8)	$ 61,513

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 7)	71
Patient Background Checks	
Hiring Expense	86
Miscellaneous Dues & Fees	1,071
Allocation from Home Office	985
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,213

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	598
Allocation from Home Office	1,833
Seminar Expense	16
Allocation from Home Office	39
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,486

**See instructions.

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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. **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? **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. $ **227** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,993**
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. $ **0** 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? **99**
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) 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	20,657	2,392	1,418	24,467	0	24,467	0	24,467
2. Food Purchase	0	28,893	0	28,893	0	28,893	-8	28,885
3. Housekeeping	0	2,202	0	2,202	0	2,202	4	2,206
4. Laundry	0	1,918	0	1,918	0	1,918	0	1,918
5. Heat and Other Utilities	0	0	16,414	16,414	0	16,414	665	17,079
6. Maintenance	11,435	2,317	5,311	19,063	0	19,063	730	19,793
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	32,092	37,722	23,143	92,957	0	92,957	1,391	94,348
9. Medical Director	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursing & Medical Records	200,452	3,367	3,049	206,868	0	206,868	0	206,868
10a. Therapy	0	0	1,041	1,041	0	1,041	0	1,041
11. Activities	0	1,622	561	2,183	0	2,183	0	2,183
12. Social Services	0	0	1,823	1,823	0	1,823	0	1,823
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	8,015	8,015	0	8,015	0	8,015
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	200,452	4,989	15,689	221,130	0	221,130	0	221,130
17. Administrative	12,421	0	100,783	113,204	0	113,204	-100,783	12,421
18. Directors Fees	0	0	0	0	0	0	2,302	2,302
19. Professional Services	0	0	1,156	1,156	0	1,156	12,109	13,265
20. Fees, Subscriptions & Promotion	0	0	1,228	1,228	0	1,228	985	2,213
21. Clerical & General Office	125	4,335	8,582	13,042	0	13,042	49,969	63,011
22. Employee Benefits & Payroll	0	0	54,300	54,300	0	54,300	7,213	61,513
23. Inservice Training & Education	0	0	170	170	0	170	0	170
24. Travel and Seminar	0	0	614	614	0	614	1,872	2,486
25. Other Admin. Staff Trans	0	0	55	55	0	55	492	547
26. Insurance-Prop.Liab.Malpractice	0	0	6,175	6,175	0	6,175	973	7,148
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	12,546	4,335	173,063	189,944	0	189,944	-24,868	165,076
29. Total General Administrative	245,090	47,046	211,895	504,031	0	504,031	-23,477	480,554
30. Depreciation	0	0	17,491	17,491	0	17,491	2,097	19,588
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	43,046	43,046	0	43,046	15,036	58,082
33. Real Estate	0	0	0	0	0	0	0	0

34.	Rent - Facility & Grounds		0	0	0	0	0	0	4,676	4,676
35.	Rent - Equipment & Vehicles		0	0	0	0	0	0	547	547
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	60,537	60,537	0	60,537	22,356	82,893
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	3,094	2,816	5,910	0	5,910	0	5,910
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	36,993	36,993	0	36,993	0	36,993
43.	Other (specify):*		0	0	0	0	0	0	0	0
44.	Total Special Cost Ce		0	3,094	39,809	42,903	0	42,903	0	42,903
45.	Grand Total		245,090	50,140	312,241	607,471	0	607,471	-1,121	606,350

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,825	2,825
2. Cash - Patient Deposits	3,578	3,578
3. Accounts & Notes Recievable	117,015	117,015
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,657	1,657
7. Other Prepaid Expenses	170	170
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	48,905	48,905
10. Total current assets	174,150	174,150
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,164	25,164
14. Buildings, at Historical Cost	509,535	509,535
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	87,984	87,984
17. Accumulated Depreciation (book methods)	-101,725	-101,725
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	5,304	5,304
23. other (specify):	592	592
24. Total Long-Term Assets	526,854	526,854
25. Total Assets	701,004	701,004
CURRENT LIABILITIES		
26. Accounts Payable	17,986	17,986
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	3,578	3,578
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	7,300	7,300
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	25,584	25,584
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	431	431

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	54,879	54,879
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	295,270	295,270
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	295,270	295,270
46.Total Liabilities	350,149	350,149
47.Total Equity	1,138,178	350,855
48.Total Liabilities and Equity	1,488,327	701,004

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	596,793
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	596,793
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	6,987
22. Laundry	0
Subtotal - Other Operating Revenue	6,987
24. Contributions	856
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	856
27. Other Revenue (specify):	38
28. Other Revenue (specify):	12,612
Subtotal - Other Revenue	12,650
30. Total Revenue	617,286
31. General Services	92,957
32. Health Care	221,130
33. General Administration	189,944
34. Ownership	60,537

35.	Special Cost Centers	5,910
35.	Provider Participation Fee	36,993
37.	Other	0
40.	Total Expenses	607,471
41.	Income Before Income Taxes	9,815
42.	Income Taxes	0
43.	Net Income or Loss for the Year	9,815