

Facility Name & ID Number Sparta Terrace

0047787 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	5,856	6
7	16	TOTALS	16	5,856	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	4,319			4,319	13
14	TOTALS	4,319			4,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.75%

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: 6/30/2016 Fiscal Year: 6/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sparta Terrace # 0047787 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	14,397	875	1,008	16,280		16,280		16,280		1
2	Food Purchase		20,528		20,528		20,528		20,528		2
3	Housekeeping		2,245		2,245		2,245		2,245		3
4	Laundry		1,206		1,206		1,206		1,206		4
5	Heat and Other Utilities			15,121	15,121		15,121	3	15,124		5
6	Maintenance	14,331	5,193	3,651	23,175		23,175	15	23,190		6
7	Other (specify):*										7
8	TOTAL General Services	28,728	30,047	19,780	78,555		78,555	18	78,573		8
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	166,142	7,474	8,303	181,919		181,919		181,919		10
10a	Therapy										10a
11	Activities		1,208		1,208		1,208		1,208		11
12	Social Services			1,466	1,466		1,466		1,466		12
13	CNA Training										13
14	Program Transportation			4,361	4,361		4,361		4,361		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	166,142	8,682	15,330	190,154		190,154		190,154		16
	C. General Administration										
17	Administrative	20,190		523,686	543,876		543,876	(523,686)	20,190		17
18	Directors Fees							4,390	4,390		18
19	Professional Services			3,047	3,047		3,047	10,549	13,596		19
20	Dues, Fees, Subscriptions & Promotions			788	788		788	2,820	3,608		20
21	Clerical & General Office Expenses	6,673	1,714	10,003	18,390		18,390	70,436	88,826		21
22	Employee Benefits & Payroll Taxes			71,243	71,243		71,243	10,813	82,056		22
23	Inservice Training & Education			179	179		179		179		23
24	Travel and Seminar			956	956		956	1,489	2,445		24
25	Other Admin. Staff Transportation			3,006	3,006		3,006	995	4,001		25
26	Insurance-Prop.Liab.Malpractice			5,542	5,542		5,542	313	5,855		26
27	Other (specify):*										27
28	TOTAL General Administration	26,863	1,714	618,450	647,027		647,027	(421,881)	225,146		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	221,733	40,443	653,560	915,736		915,736	(421,863)	493,873		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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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			17,051	17,051		17,051	2,519	19,570			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,648	30,648		30,648	14,342	44,990			32
33	Real Estate Taxes			2	2		2	(2)				33
34	Rent-Facility & Grounds			56	56		56	(56)				34
35	Rent-Equipment & Vehicles							2,011	2,011			35
36	Other (specify):*											36
37	TOTAL Ownership			47,757	47,757		47,757	18,814	66,571			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,885		2,885		2,885		2,885			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,387	26,387		26,387		26,387			42
43	Other (specify):* Disallowed Costs			1,565	1,565		1,565	(1,565)				43
44	TOTAL Special Cost Centers		2,885	27,952	30,837		30,837	(1,565)	29,272			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	221,733	43,328	729,269	994,330		994,330	(404,614)	589,716			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,565)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(403,049)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (404,614)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (404,614)		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

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BHF USE ONLY							
48		49		50		51	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallowed HO Costs	\$ (402,991)	43	1
2	Offset rental income against expense	(56)	34	2
3	Disallow Real Estate Taxes	(2)	33	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
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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	(403,049)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Utilities	\$	Progressive Housing, Inc.	100.00%	\$ 3	\$ 3	1
2	V	6 Maintenance		Progressive Housing, Inc.	100.00%	15	15	2
3	V	17 Administrative	523,686	Progressive Housing, Inc.	100.00%		(523,686)	3
4	V	18 Director Fees		Progressive Housing, Inc.	100.00%	4,390	4,390	4
5	V	19 Professional Services		Progressive Housing, Inc.	100.00%	10,549	10,549	5
6	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,820	2,820	6
7	V	21 Clerical and General Office	14	Progressive Housing, Inc.	100.00%	70,450	70,436	7
8	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	10,813	10,813	8
9	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,489	1,489	9
10	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	995	995	10
11	V	26 Insurance		Progressive Housing, Inc.	100.00%	313	313	11
12	V	30 Depreciation		Progressive Housing, Inc.	100.00%	2,519	2,519	12
13	V	32 Interest	54	Progressive Housing, Inc.	100.00%	14,396	14,342	13
14	Total		\$ 523,754			\$ 118,752	\$ * (405,002)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							15
16	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	2,011	2,011	16
17	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	402,991	402,991	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		\$			\$ 405,002	\$ * 405,002	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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			Aviston Terrace	Aviston	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-closed	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	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

SEE ACCOUNTANTS' PREPARATION REPORT

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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	9,031	3Hrs/MTG	1.00	Dir. Fees	\$ 569	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,983		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

SEE ACCOUNTANTS' PREPARATION REPORT

Sparta Terrace
0047787
6/30/2016

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Cora Flota	Edward Childers	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Eileen Mullin	Misc Exp	Total
Sparta Terrace	569	569	569	569	569	569	569	405	4,390
Ellner Terrace	569	569	569	569	569	569	569	405	4,390
Taylorville Terrace	569	569	569	569	569	569	569	405	4,390
Aviston Terrace	569	569	569	569	569	569	569	405	4,390
Briarbrook Place	569	569	569	569	569	569	569	405	4,390
Harris Place	569	569	569	569	569	569	569	405	4,390
Joshua Manor	569	569	569	569	569	569	569	405	4,390
Terra Estates								157	157
Park Place	569	569	569	569	569	569	569	405	4,390
Western Gardens	249	249	249	249	249	249	249	(27)	1,713
Galaxy	284	284	284	284	284	284	284	(32)	1,957
Cardinal	284	284	284	284	284	284	284	(32)	1,957
Bill Goat Hill	284	284	284	284	284	284	284	(32)	1,957
Country Club Hill	213	213	213	213	213	213	213	151	1,643
Lee Street	213	213	213	213	213	213	213	151	1,643
Baker Street	213	213	213	213	213	213	213	151	1,643
182nd Street	213	213	213	213	213	213	213	151	1,643
Osage	213	213	213	213	213	213	213	151	1,643
Oakwood	213	213	213	213	213	213	213	151	1,643
Blair	-	-	-	-	-	-	-	318	318
Lowell	249	249	249	249	249	249	249	177	1,917
Marquette	249	249	249	249	249	249	249	177	1,917
Cherry	213	213	213	213	213	213	213	151	1,643
Luella	284	284	284	284	284	284	284	202	2,191
Olivia	249	249	249	249	249	249	249	177	1,917
Huron	213	213	213	213	213	213	213	151	1,643
Wilshire	249	249	249	249	249	249	249	177	1,917
Constance	284	284	284	284	284	284	284	193	2,182
175th Place	249	249	249	249	249	249	249	178	1,918
Sauganash	180	180	180	180	180	180	180	126	1,383
Steger	249	249	249	249	249	249	249	177	1,917
Waltonville	-	-	-	-	-	-	-	244	244
Mt. Vernon	-	-	-	-	-	-	-	388	388
Total BOD Expense	9,600	9,600	9,600	9,600	9,600	9,600	9,600	7,016	74,216

Facility Name & ID Number Sparta Terrace

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Progressive Housing, Inc.
 Street Address 20180 Governors Dr., Suite 300
 City / State / Zip Code Olympia Fields, IL 60461
 Phone Number (708) 283-1530
 Fax Number (708) 283-2470

1	2	3	4	5	6	7	8	9	
Schedule V 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	5	Utilities	Bed Capacity/Specific Alloc.	270	29	47	16	\$ 3	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	270	29	258	16	15	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	270	29	74,216	16	4,390	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	270	29	180,145	16	10,549	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	270	29	49,923	16	2,820	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	270	29	1,229,303	16	70,450	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	270	29	193,338	16	10,813	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	270	29	27,210	16	1,489	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	270	29	17,338	16	995	9
10	26	Insurance	Bed Capacity/Specific Alloc.	270	29	7,498	16	313	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	270	29	43,850	16	2,519	11
12	32	Interest	Bed Capacity/Specific Alloc.	270	29	250,479	16	14,396	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	270	29	41,954	16	2,011	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	270	29	4,719,330	16	402,991	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 6,834,889	\$ 1,076,524	\$ 523,754	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Sparta Terrace

0047787

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 295,270	\$ 270,687	08/15/26	6.7500	\$ 30,648	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7	Allocation from Home Office-Interest										13,668	7						
8	Allocation from Home Office-Amortization										728	8						
9	TOTAL Facility Related						\$ 295,270	\$ 270,687			\$ 45,044	9						
B. Non-Facility Related*																		
10												10						
11												11						
12									Interest Income Offset-HO		(54)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (54)	14						
15	TOTALS (line 9+line14)						\$ 295,270	\$ 270,687			\$ 44,990	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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 2015 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.)

2015 \$ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2016 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:

2011	<u> </u>	8
2012	<u> </u>	9
2013	<u> </u>	10
2014	<u> </u>	11
2015	<u> </u>	12

N/A - Not for profit entity

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sparta Terrace COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0047787

CONTACT PERSON REGARDING THIS REPORT Lawrence Manson

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
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 X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

7/1/2015 Ending:

6/30/2016

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:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility, Allocated from Home Office, and TOTALS.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2011		\$ 475,000 *	\$ 11,875	40	\$ 11,875	\$	\$ 64,331	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		15			1,133	15
16	Paint and Ceramic Tile		1999	826		15			826	16
17	Secind Backflow Prevention		1999	1,163		15			1,163	17
18	Tile		1999	3,116		15			3,116	18
19	Shower		1999	1,113		15			1,113	19
20	Parking Lot		2002	2,850	190	15	190		2,676	20
21	Bathroom Remodel		2006	3,022	201	15	201		1,956	21
22	Bathroom Remodel		2008	3,110	207	15	207		1,803	22
23	Handrails		2008	638	43	15	43		329	23
24	Backflow Repair		2011	677	45	15	45		228	24
25	New Air Conditioner		2011	3,016	201	10	201		1,055	25
26	New Floor-Bedroom		2011	372	25	15	25		109	26
27	New Furnace		2012	2,385	159	15	159		637	27
28	Air Compressor-Sprinkler System		2012	1,722	115	15	115		441	28
29	Replaced Flooring		2014	1,310	87	15	87		181	29
30	Install 2 dry pendants in porch & replace leaking close nipple		2014	2,745	183	15	183		297	30
31										31
32										32
33										33
34										34
35	Allocation from Home Office			10,973			450	450		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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sparta Terrace

0047787

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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)	\$	522,880	\$	13,331	\$	13,781	\$	450	\$	89,103	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

7/1/2015

Ending:

6/30/2016

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	\$ 20,700	\$ 2,172	\$ 2,172	\$	5-10Yrs	\$ 13,139	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	31,139	634	634		5-10Yrs	31,139	73
74	Allocated from Home Office	21,506		1,687	1,687		16,676	74
75	TOTALS	\$ 73,345	\$ 2,806	\$ 4,493	\$ 1,687		\$ 60,954	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	896	896		5	2,594	77
78	Resident Transportation	Capitalized Repairs	2016	528	18	18		5	18	78
79	Allocated from Home Office			551		382	382			79
80	TOTALS			\$ 24,143	\$ 914	\$ 1,296	\$ 382		\$ 21,197	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)	\$ 652,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,051	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,570	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,519	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,254	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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					56			5
6					(56)			6
7	TOTAL				\$			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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 2,011 Description: Allocated from Home Office - postage machine \$88, copier \$1,249, storage \$674

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input 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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					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				2,885		2,885	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			\$		\$	\$ 2,885		\$ 2,885	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 62,437	\$ 62,437	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>25,185</u>)	66,165	66,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Reserves/Deposits</u>	78,318	78,318	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 212,631	\$ 212,631	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000	31,657	13
14	Buildings, at Historical Cost	34,500	522,880	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	54,969	97,488	16
17	Accumulated Depreciation (book methods)	(44,012)	(171,254)	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 <u>Loan Costs</u>	5,792	5,792	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 76,249	\$ 486,563	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 288,880	\$ 699,194	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 16,811	\$ 16,811	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,501	24,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,614	1,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,292	15,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	16,939	16,939	36
37	<u>Deposits/Deferred Income</u>	64,583	64,583	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 139,740	\$ 139,740	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	270,687	270,687	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Bond Fund</u>	19,177	19,177	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 289,864	\$ 289,864	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 429,604	\$ 429,604	46
47	TOTAL EQUITY(page 18, line 24)	\$ (140,724)	\$ 269,590	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 288,880	\$ 699,194	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 360,642	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 360,642	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(501,366)	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)	\$ (501,366)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (140,724)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Sparta Terrace

0047787

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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	\$ 484,348	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 484,348	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	4,240	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,240	23
D. Non-Operating Revenue			
24	Contributions	171	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 171	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	4,205	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,205	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 492,964	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	78,555	31
32	Health Care	190,154	32
33	General Administration	647,027	33
B. Capital Expense			
34	Ownership	47,757	34
C. Ancillary Expense			
35	Special Cost Centers	4,450	35
36	Provider Participation Fee	26,387	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 994,330	40
41	Income before Income Taxes (line 30 minus line 40)**	(501,366)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (501,366)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 484,348	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)	\$ 484,348	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Sch 19A 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Sparta Terrace
0047787
6/30/2016

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: **7/1/2015**

Ending:

6/30/2016

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	577	13,633	21.74	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	1,394	14,397	8.98	15
16	Dishwashers				16
17	Maintenance Workers	965	14,331	13.21	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	723	20,190	24.06	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	280	6,673	21.88	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	72	1,211	16.82	28
29	Resident Services Coordinator	1,319	23,451	16.85	29
30	Habilitation Aides (DD Homes)	13,123	127,847	9.10	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,453	221,733 *	11.10	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	19	\$ 1,008	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	811	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	27	1,466	L12, C3	45
46	Other(specify) <u>Dental</u>	24	7,492	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	70	\$ 11,977		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina Durbin	Administrator	0	\$ 7,159	Workers' Compensation Insurance	\$ 22,733	IDPH License Fee	\$	
Karla Rogers	Administrator	0	13,031	Unemployment Compensation Insurance	10,071	Advertising: Employee Recruitment		
				FICA Taxes	16,280	Health Care Worker Background Check		
				Employee Health Insurance	17,929	(Indicate # of checks performed <u>7</u>)	245	
				Employee Meals	3,790	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	299	
				Life Insurance	252	Miscellaneous Dues & Fees	244	
				Other Employee Benefits	188			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 20,190	Allocated from Home Office	10,813	Allocated from Home Office	2,820	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 82,056	Less: Public Relations Expense ()
Description			Amount				Non-allowable advertising ()	
Allocated from Progressive Housing, Inc.			\$ 523,686				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 523,686	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Amount	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
Paychex	Payroll Service		\$ 3,047	N/A			Out-of-State Travel	
							In-State Travel	
							797	
							Seminar Expense	
							159	
							Allocated from Home Office	
							1,489	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 3,047	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)
							\$ 2,445	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

