		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0040360

Facility Name: Park Place

Address: 205 Park Avenue (Number) Pana (City) 62557 (Zip Code)

County: Washington

Telephone Number: (217) 562-5516 **Fax #** (217) 562-5516

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1993

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501 C (3)

In the event there are further questions about this report, please contact:
Name: Jerry Johnson **Telephone Number:** (309) 685-0595 ext 302
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 07/01/2009 to 06/30/2010 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) Michael Kaplan, Consultant
(Firm Name & Address)
(Telephone) (847) 772-7419 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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	4,723			4,723	13
14	TOTALS	4,723			4,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.87%

D. How many bed-hold days during this year were paid by the Department?
262 (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 [ ] Note : 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 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/30/1993 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: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	15,061	1,713	2,138	18,912		18,912		18,912			1
2	Food Purchase		30,962		30,962		30,962		30,962			2
3	Housekeeping		687		687		687	221	908			3
4	Laundry		1,511	406	1,917		1,917		1,917			4
5	Heat and Other Utilities			13,387	13,387		13,387	1,291	14,678			5
6	Maintenance	3,586		5,203	8,789		8,789	811	9,600			6
7	Other (specify):*											7
8	**TOTAL General Services**	18,647	34,873	21,134	74,654		74,654	2,323	76,977			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	146,638	6,371	1,395	154,404		154,404	1	154,405			10
10a	Therapy											10a
11	Activities		817		817		817		817			11
12	Social Services			2,218	2,218		2,218		2,218			12
13	CNA Training											13
14	Program Transportation			3,065	3,065		3,065		3,065			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	146,638	7,188	11,478	165,304		165,304	1	165,305			16
	C. General Administration											
17	Administrative											17
18	Directors Fees			2,498	2,498		2,498		2,498			18
19	Professional Services			11,490	11,490		11,490	3,604	15,094			19
20	Dues, Fees, Subscriptions & Promotions			1,329	1,329		1,329	701	2,030			20
21	Clerical & General Office Expenses		1,488	10,619	12,107		12,107	39,326	51,433			21
22	Employee Benefits & Payroll Taxes			33,701	33,701		33,701	6,174	39,875			22
23	Inservice Training & Education			47	47		47		47			23
24	Travel and Seminar			3,132	3,132		3,132	808	3,940			24
25	Other Admin. Staff Transportation			406	406		406	160	566			25
26	Insurance-Prop.Liab.Malpractice			2,861	2,861		2,861	1,047	3,908			26
27	Other (specify):*											27
28	**TOTAL General Administration**		1,488	66,083	67,571		67,571	51,820	119,391			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	165,285	43,549	98,695	307,529		307,529	54,144	361,673			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 Park Place #0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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			13,691	13,691		13,691	1,998	15,689			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,725	33,725		33,725	253	33,978			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							633	633			34
35	Rent-Equipment & Vehicles							126	126			35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,416	47,416		47,416	3,010	50,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,608	29,608		29,608		29,608			42
43	Other (specify):* **Non-Allowable Cos**			168,595	168,595		168,595	(168,595)				43
44	**TOTAL Special Cost Centers**			198,203	198,203		198,203	(168,595)	29,608			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	165,285	43,549	344,314	553,148		553,148	(111,441)	441,707			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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ (146,281)	43	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(79)	43		17
18	Fines and Penalties	(22,200)	43		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				24
25	Fund Raising, Advertising and Promotional	(35)	43		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 Pg 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (168,612)		$	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)	57,171		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 57,171		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (111,441)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Park Place

ID# 0040360

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc	100	See Attached Related Party Schedule Sch 6A		See Attached Related Party Schedule Sch 6A		
See Attached Schedule 7A						

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		18	Board Fees	$ 357	Progressive Housing, Inc.	100.00%	$ 357	$	1
2	V		19	Professional Fees	723	Progressive Housing, Inc.	100.00%	723		2
3	V		20	License, Dues	1	Progressive Housing, Inc.	100.00%	1		3
4	V		21	General Office	275	Progressive Housing, Inc.	100.00%	275		4
5	V		23	Inservices Travel		Progressive Housing, Inc.	100.00%			5
6	V		24	Travel Seminar	34	Progressive Housing, Inc.	100.00%	34		6
7	V		32	Interest Income	16	Progressive Housing, Inc.	100.00%	16		7
8	V		43	Non-allowable		Progressive Housing, Inc.	100.00%			8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,406			$ 1,406	$ *	14

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	18	Board Fees	$ 2,141	Progressive Housing, Inc.	100.00%	$ 2,141	$	15
16	V	19	Professional Fees	10,440	Progressive Housing, Inc.	100.00%	10,440		16
17	V	20	License, Dues	1	Progressive Housing, Inc.	100.00%	1		17
18	V	21	General Office	1,951	Progressive Housing, Inc.	100.00%	1,951		18
19	V	23	Inservices Travel		Progressive Housing, Inc.	100.00%			19
20	V	24	Travel Seminar	258	Progressive Housing, Inc.	100.00%	258		20
21	V	32	Interest Income	139	Progressive Housing, Inc.	100.00%	139		21
22	V	43	Non-allowable	(73)	Progressive Housing, Inc.	100.00%	(73)		22
23	V	24	Travel Seminar	102	Progressive Housing, Inc.	100.00%	102		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			$ 14,959			$ 14,959	$ *	39

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	3	Housekeeping	$	Center For Residential Management	Parent Co.	$ 221	$ 221	15
16	V	5	Utilities		Center For Residential Management	Parent Co.	1,291	1,291	16
17	V	6	Maintenance		Center For Residential Management	Parent Co.	811	811	17
18	V	10	Nursing Supplies		Center For Residential Management	Parent Co.	1	1	18
19	V	17	Administrative Cost		Center For Residential Management	Parent Co.			19
20	V	19	Professional Fees		Center For Residential Management	Parent Co.	3,604	3,604	20
21	V	20	Dues, Fees		Center For Residential Management	Parent Co.	701	701	21
22	V	21	Clerical & General		Center For Residential Management	Parent Co.	39,326	39,326	22
23	V	22	Employment Benefits		Center For Residential Management	Parent Co.	6,174	6,174	23
24	V	23	Inservices Education		Center For Residential Management	Parent Co.			24
25	V	24	Travel Seminar		Center For Residential Management	Parent Co.	808	808	25
26	V	25	Other Admin Staff Trans.		Center For Residential Management	Parent Co.	160	160	26
27	V	26	Insurance		Center For Residential Management	Parent Co.	1,047	1,047	27
28	V	30	Depreciation		Center For Residential Management	Parent Co.	1,998	1,998	28
29	V	32	Interest		Center For Residential Management	Parent Co.	270	270	29
30	V	33	Real Estate Taxes		Center For Residential Management	Parent Co.			30
31	V	34	Rent		Center For Residential Management	Parent Co.	633	633	31
32	V	35	Equipment Rental		Center For Residential Management	Parent Co.	126	126	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 57,171	$ * 57,171	39

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

SCHEDULE 6A

RELATED PARTY SCHEDULE

Schedule VII - Related Parties
Page 6, Section A, Column 2 Related Facilities

NAME	FACILITY NAME	CITY	STATE
Progressive Housing Inc.	Lakeview Living Center	Chicago	IL
	Sparta Terrace	Sparta	IL
	Ellner Terrace	Evansville	IL
	Taylorville Terrace	Taylorville	IL
Progressive Housing Inc.	Aviston Terrace	Aviston	IL
	Briarbrook Place	East Peoria	IL
	Harris Place	East Peoria	IL
	Joshua Manor	Hoyleton	IL
	Terra Estates	Hoyleton	IL
	Park Place	Pana	IL
	Cardinal	Woodlawn	IL
	Western Gardens	MT. Vernon	IL
	Galaxy	Woodlawn	IL
	Bill Goat Hill	MT. Vernon	IL
	Country Club Hill	Country Club Hills	IL
	Lee street	Country Club Hills	IL
	Baker Street	Country Club Hills	IL
	182nd Street	Country Club Hills	IL
	Osage	Park Forest	IL
	Oakwood	Park Forest	IL
	Blair	Park Forest	IL
	Lowell	Hazelcrest	IL
	Marquette	Park Forest	IL
	Cherry	Park Forest	IL
	Luella	Sauk Village	IL
	Olivia	Sauk Village	IL
	Huron	Park Forest	IL
	Wilshire	Park Forest	IL
	Constance	Sauk Village	IL

Schedule VII - Related Parties
Page 6, Section A, Column 3 Other Related Business Entities

Name	City	Type of Business
Center for Residential Managemen	Peoria	Management Company
Progressive Housing, Inc.	Peoria	ICF/DD Provider

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Schroeder	Secretary	Board Member	None	6,427	3Hrs/MTG	1.00	Dir. Fees	$ 373	L18,C8	1
2	Shawn Jeffers	Chairman	Board Member	None	7,562	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	2
3	Edward Childers	Vice Chairman	Board Member	None	10,965	3Hrs/MTG	1.00	Dir. Fees	635	L18,C8	3
4	Robert Bauer	Director	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	4
5	Cora Flota	Director	Board Member	None	1,512	3Hrs/MTG	1.00	Dir. Fees	88	L18,C8	5
6	Orland Bauer	Treasurer	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,498		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**

Park Place
0040360
06/30/2010

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.	Ron Schroder	Edward Childers	Robert Bauer	Cora Flota	Orland Bauer	Shawn Jeffers	Total
Lakeview Living Center	630	1,072	812	150	812	739	4,215
Sparta Terrace	373	635	482	88	482	438	2,498
Ellner Terrace	373	635	482	88	482	438	2,498
Taylorville Terrace	373	635	482	88	482	438	2,498
Aviston Terrace	373	635	482	88	482	438	2,498
Briarbrook Place	373	635	482	88	482	438	2,498
Harris Place	373	635	482	88	482	438	2,498
Joshua Manor	373	635	482	88	482	438	2,498
Terra Estates	373	635	482	88	482	438	2,498
Park Place	373	635	482	88	482	438	2,498
Cardinal	186	318	241	44	241	219	1,249
Western Gardens	186	318	241	44	241	219	1,249
Galaxy	186	318	241	44	241	219	1,249
Bill Goat Hill	186	318	241	44	241	219	1,249
Country Club Hill	140	238	180	33	181	164	936
Lee Street	140	238	180	33	181	164	936
Baker Street	140	238	180	34	180	164	936
182nd Street	140	238	180	34	180	164	936
Osage	140	238	180	34	180	164	936
Oakwood	140	238	180	34	180	164	936
Blair	140	239	180	33	180	164	936
Lowell	140	239	180	33	180	164	936
Marquette	140	239	180	33	180	164	936
Cherry	140	239	180	33	180	164	936
Luella	140	238	181	33	180	164	936
Olivia	140	238	181	33	180	164	936
Huron	141	238	180	33	180	164	936
Wilshire	141	238	180	33	180	164	936
Constance	107	205	164	16	164	147	803
Total PHI	6,800	11,600	8,800	1,600	8,800	8,000	45,600

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

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: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	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	18	Board Fees	Number of Beds	287		$ 6,400	$	16	$ 357	1
2	19	Professional Fees	Number of Beds	287		12,968		16	723	2
3	20	License, Dues	Number of Beds	287		10		16	1	3
4	21	General Office	Number of Beds	287		4,934		16	275	4
5	23	Inservices Travel	Number of Beds	287				16	0	5
6	24	Travel Seminar	Number of Beds	287		609		16	34	6
7	32	Interest Income	Number of Beds	287		285		16	16	7
8	43	Non-allowable	Number of Beds	287				16	0	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					$ 25,206	$		$ 1,406	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

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: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	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	18	Board Fees	Number of Beds	293		$ 39,200	$	16	$ 2,141	1
2	19	Professional Fees	Number of Beds	293		191,187		16	10,440	2
3	20	License, Dues	Number of Beds	293		10		16	1	3
4	21	General Office	Number of Beds	293		35,726		16	1,951	4
5	23	Inservices Travel	Number of Beds	293				16		5
6	24	Travel Seminar	Number of Beds	293		4,722		16	258	6
7	32	Interest Income	Number of Beds	293		2,540		16	139	7
8	43	Non-allowable	Number of Beds	293		(1,344)		16	(73)	8
9	24	Travel Seminar	Number of Facility	13		1,329		1	102	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					$ 273,370	$		$ 14,959	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

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: Center for Residential Management
Street Address: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	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	Revenue	12,610,469		$ 4,888	$	570,968	$ 221	1
2	5	Utilities	Revenue	12,610,469		28,505		570,968	1,291	2
3	6	Maintenance	Revenue	12,610,469		17,904		570,968	811	3
4	10	Nursing Supplies	Revenue	12,610,469		29		570,968	1	4
5	17	Administrative Cost	Revenue	12,610,469				570,968		5
6	19	Professional Fees	Revenue	12,610,469		79,603		570,968	3,604	6
7	20	Dues, Fees	Revenue	12,610,469		15,474		570,968	701	7
8	21	Clerical & General	Revenue	12,610,469		868,566	741,167	570,968	39,326	8
9	22	Employment Benefits	Revenue	12,610,469		136,351		570,968	6,174	9
10	23	Inservices Education	Revenue	12,610,469				570,968		10
11	24	Travel Seminar	Revenue	12,610,469		17,846		570,968	808	11
12	25	Other Admin Staff Trans.	Revenue	12,610,469		3,527		570,968	160	12
13	26	Insurance	Revenue	12,610,469		23,128		570,968	1,047	13
14	30	Depreciation	Revenue	12,610,469		44,128		570,968	1,998	14
15	32	Interest	Revenue	12,610,469		5,957		570,968	270	15
16	33	Real Estate Taxes	Revenue	12,610,469				570,968		16
17	34	Rent	Revenue	12,610,469		13,987		570,968	633	17
18	35	Equipment Rental	Revenue	12,610,469		2,792		570,968	126	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,262,685	$ 741,167		$ 57,171	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 519,382	$ 481,123	08/15/26	6.7500	$ 32,379	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Vendor Finance Charge		X	Working Capital							137	6
7	Allocation from Parent	X		Working Capital							425	7
8	Amort of Loan Cost		X	Facility Acquisition							1,054	8
9	TOTAL Facility Related						$ 519,382	$ 481,123			$ 33,995	9
	B. Non-Facility Related*											
10												10
11	Offset Interest Income										(17)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17)	14
15	TOTALS (line 9+line14)						$ 519,382	$ 481,123			$ 33,978	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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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.)	2009	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040360

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 2009 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 2009.

	(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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,625 B. General Construction Type: Exterior 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).

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	Resident Care	13,916	1993	$ 20,000	1
2					2
3	TOTALS	13,916		$ 20,000	3

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1992	$ 406,000	$ 10,150	40	$ 10,150	$	$ 174,240	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	6,700	231	15	231		6,684	9
10	Heating Piping			1997	650	44	15	44		541	10
11	Shower			2000	2,266	151	15	151		1,435	11
12	Flooring			2001	548	37	15	37		314	12
13	Water Services Repairs			2004	1,071	71	15	71		434	13
14	Kitchen Coutner Tops			2005	625	41	15	41		222	14
15	Kitchen Cabinets			2005	3,445	230	15	230		1,248	15
16	Kitchen Remodel			2005	1,429	95	15	95		492	16
17	Air Conditioning Repair			2005	1,650	110	15	110		532	17
18	Bathroom Remodel			2006	710	47	15	47		169	18
19	Bedroom Remodel			2007	1,070	71	15	71		190	19
20	Gazebo			2007	1,896	126	15	126		327	20
21	Alarm Repairs			2008	1,875	125	15	125		261	21
22	Heating/ Cooling			2009	1,928	129	15	129		150	22
23	Building Improvements			2009	806	54	15	54		58	23
24	Repair to Water Main			2009	2,083	116	15	116		116	24
25											25
26											26
27											27
28											28
29											29
30	Allocation from Parent Company							650	650		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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 434,752	$ 11,828		$ 12,478	$ 650	$ 187,413	70

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 13,343	$ 1,548	$ 1,548	$	5-10Yrs	$ 8,000	71
72	Current Year Purchases	422	24	24		5-10Yrs	24	72
73	Fully Depreciated Assets	7,983				5-10Yrs	7,983	73
74	Allocated From Parent Co.			1,348	1,348			74
75	TOTALS	$ 21,748	$ 1,572	$ 2,920	$ 1,348		$ 16,007	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trans	2004 Ford	2004	$ 27,458	$ 93	$ 93	$	5	$ 27,458	76
77	Resident Trans	2004 Ford	2008	992	198	198		5	430	77
78										78
79										79
80	TOTALS			$ 28,450	$ 291	$ 291	$		$ 27,888	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)	$ 504,950	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,691	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,689	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,998	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 231,308	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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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 [X] 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	Allocation from Parent Company				633			5
6								6
7	TOTAL				$ 633 **			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 [X] NO Terms: N/A *

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.	/2011	$ N/A
13.	/2012	$ N/A
14.	/2013	$ 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: $ 126 Description: Allocation from Parent Company Postage Meter, Lift
(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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L10, C3	visits		19	754		19	754	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$	19	$ 754	$	19	$ 754	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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 (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	$ 300	$ 300	1
2	Cash-Patient Deposits	4,177	4,177	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,254))	163,998	163,998	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108	108	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,432,765	1,432,765	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,601,348	$ 1,601,348	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	434,752	434,752	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	50,198	50,198	16
17	Accumulated Depreciation (book methods)	(231,308)	(231,308)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	75,888	75,888	21
22	Other Long-Term Assets (spe **Loan Cost**	10,424	10,424	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 359,954	$ 359,954	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,961,302	$ 1,961,302	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,368	$ 41,368	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,177	4,177	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,051	10,051	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,111	12,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17C	70,224	70,224	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 137,931	$ 137,931	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	481,123	481,123	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)**	$ 481,123	$ 481,123	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 619,054	$ 619,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,342,248	$ 1,342,248	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,961,302	$ 1,961,302	48

***(See instructions.)**

Park Place
0040360
06/30/2010

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Prepaid Expense	19,304	19,304
Accrued Expense	250	250
Accrued Workshop	46,809	46,809
Accrued Insurance Payable	3,861	3,861
Total Line 36 - Other Current Liabilities(specify):	**70,224**	**70,224**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,176,720	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,176,720	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	165,528	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)**	$ 165,528	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)**	$ 1,342,248	24 *

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 570,968	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 570,968	3
	B. Ancillary Revenue		
4	Day Care	146,281	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 146,281	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	1,410	24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,427	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 718,676	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	74,654	31
32	Health Care	165,304	32
33	General Administration	67,571	33
	B. Capital Expense		
34	Ownership	47,416	34
	C. Ancillary Expense		
35	Special Cost Centers	168,595	35
36	Provider Participation Fee	29,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 553,148	40
41	**Income before Income Taxes (line 30 minus line 40)****	165,528	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 165,528	43

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

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

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

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

Facility Name Park Place
ID# 0040360
FYE 06/30/2010

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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					3
4	Licensed Practical Nurses	633	638	7,018	11.00	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	1,681	1,825	15,061	8.25	15
16	Dishwashers					16
17	Maintenance Workers	424	428	3,586	8.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,926	2,122	24,391	11.49	29
30	Habilitation Aides (DD Homes)	13,161	13,979	115,229	8.24	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,825	18,992	$ 165,285 *	$ 8.70	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	24	$ 1,928	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	26	641	L10, C3	38
39	Pharmacist Consultant				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	29	2,218	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	79	$ 9,587		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 Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
N/A Allocated From CRM			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Allocated from Center For Residential Management	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Schuyler Roche	Legal	$ 139
Wells Fargo	Bond Trustee	164
Krieg, Devault	Legal	2,588
Personnel Planners	UC Consultant	197
Heinold-Banwart, LTD	Accounting	7,532
Barbara Weiner	Legal	82
Wildman, Harrold, Allen	Legal	778
Westervelt, Johnson, Nicoll	Legal	10
Allocation from Parent Company		3,604
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,094

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,321
Unemployment Compensation Insurance	3,977
FICA Taxes	12,621
Employee Health Insurance	9,089
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Moral	320
403B Retirement Contribution	200
Drug Test	173
Allocation from Parent Company	6,174
TOTAL (agree to Schedule V, line 22, col.8)	$ 39,875

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	131
Health Care Worker Background Check	95
(Indicate # of checks performed)	
Patient Background Checks	
Vehicle License	
IHCA Dues	883
Miscellaneous Dues & Fees	220
Subscriptons	
Allocation from Parent Company	701
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,030

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 9
In-State Travel	2,774
Allocation from Parent Company	710
Seminar Expense	349
Allocation from Parent Company	98
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 883**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **N/A** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,602** 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. $ **29,608**
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? **96**
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? **N/A**
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.