FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0040360

Facility Name: Park Place

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

County: Christian

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: Tracey Peloza **Telephone Number:** (708) 283-1530
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,413			5,413	13
14	TOTALS	5,413			5,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.69%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 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: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Operating Expenses	Costs Per General Ledger				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	16,957	1,725	1,668	20,350		20,350		20,350			1
2	Food Purchase		40,005		40,005		40,005	(8)	39,997			2
3	Housekeeping		2,403		2,403		2,403	4	2,407			3
4	Laundry		1,049		1,049		1,049		1,049			4
5	Heat and Other Utilities			15,739	15,739		15,739	676	16,415			5
6	Maintenance	7,155	1,733	4,504	13,392		13,392	743	14,135			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	24,112	46,915	21,911	92,938		92,938	1,415	94,353			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	161,953	4,807	2,298	169,058		169,058		169,058			10
10a	Therapy											10a
11	Activities		1,286	408	1,694		1,694		1,694			11
12	Social Services			1,345	1,345		1,345		1,345			12
13	CNA Training											13
14	Program Transportation			6,473	6,473		6,473		6,473			14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	161,953	6,093	15,324	183,370		183,370		183,370			16
	C. General Administration											
17	Administrative	393		99,240	99,633		99,633	(99,240)	393			17
18	Directors Fees							2,342	2,342			18
19	Professional Services			1,078	1,078		1,078	8,945	10,023			19
20	Dues, Fees, Subscriptions & Promotions			1,010	1,010		1,010	1,003	2,013			20
21	Clerical & General Office Expenses	125	3,869	15,549	19,543		19,543	50,863	70,406			21
22	Employee Benefits & Payroll Taxes			42,412	42,412		42,412	7,337	49,749			22
23	Inservice Training & Education			125	125		125		125			23
24	Travel and Seminar			352	352		352	1,404	1,756			24
25	Other Admin. Staff Transportation			56	56		56	498	554			25
26	Insurance-Prop.Liab.Malpractice			4,503	4,503		4,503	989	5,492			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	518	3,869	164,325	168,712		168,712	(25,859)	142,853			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	186,583	56,877	201,560	445,020		445,020	(24,444)	420,576			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:** 07/01/2011 **Ending:** 06/30/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,989	12,989		12,989	2,133	15,122			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,416	33,416		33,416	15,259	48,675			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,718	4,718			34
35	Rent-Equipment & Vehicles							556	556			35
36	Other (specify):*											36
37	**TOTAL Ownership**			46,405	46,405		46,405	22,666	69,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,264	1,549	5,813		5,813		5,813			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,970	32,970		32,970		32,970			42
43	Other (specify):* Non-allowable Costs											43
44	**TOTAL Special Cost Centers**		4,264	34,519	38,783		38,783		38,783			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	186,583	61,141	282,484	530,208		530,208	(1,778)	528,430			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: 07/01/2011 Ending: 06/30/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(1,214)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(564)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,778)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,778)		37

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

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

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

Park Place

ID# 0040360

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	(8)	0	0	0	0	0	0	0	0	0	(8)	2
3	Housekeeping	0	4	0	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	676	0	0	0	0	0	0	0	0	0	676	5
6	Maintenance	0	743	0	0	0	0	0	0	0	0	0	743	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,415	0	0	0	0	0	0	0	0	0	1,415	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(99,240)	0	0	0	0	0	0	0	0	0	(99,240)	17
18	Directors Fees	0	2,342	0	0	0	0	0	0	0	0	0	2,342	18
19	Professional Services	0	8,945	0	0	0	0	0	0	0	0	0	8,945	19
20	Fees, Subscriptions & Promotions	0	1,003	0	0	0	0	0	0	0	0	0	1,003	20
21	Clerical & General Office Expenses	0	50,863	0	0	0	0	0	0	0	0	0	50,863	21
22	Employee Benefits & Payroll Taxes	0	7,337	0	0	0	0	0	0	0	0	0	7,337	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,404	0	0	0	0	0	0	0	0	0	1,404	24
25	Other Admin. Staff Transportation	0	498	0	0	0	0	0	0	0	0	0	498	25
26	Insurance-Prop.Liab.Malpractice	0	989	0	0	0	0	0	0	0	0	0	989	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(25,859)	0	0	0	0	0	0	0	0	0	(25,859)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(24,444)	0	0	0	0	0	0	0	0	0	(24,444)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	2,133	0	0	0	0	0	0	0	0	2,133	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	15,259	0	0	0	0	0	0	0	0	15,259	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	4,718	0	0	0	0	0	0	0	0	4,718	34
35	Rent-Equipment & Vehicles	0	0	556	0	0	0	0	0	0	0	0	556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	22,666	0	0	0	0	0	0	0	0	22,666	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,778)	0	1,778	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,778)	0	1,778	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,778)	(24,444)	24,444	0	0	0	0	0	0	0	0	(1,778)	45

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$ 8	Progressive Housing, Inc.	100.00%	$	$ (8)	1
2	V	3	Housekeeping		Progressive Housing, Inc.	100.00%	4	4	2
3	V	5	Utilities		Progressive Housing, Inc.	100.00%	676	676	3
4	V	6	Maintenance		Progressive Housing, Inc.	100.00%	743	743	4
5	V	17	Administrative	99,240	Progressive Housing, Inc.	100.00%		(99,240)	5
6	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,342	2,342	6
7	V	19	Professional Services		Progressive Housing, Inc.	100.00%	8,945	8,945	7
8	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,003	1,003	8
9	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	50,863	50,863	9
10	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	7,337	7,337	10
11	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,404	1,404	11
12	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	498	498	12
13	V	26	Insurance		Progressive Housing, Inc.	100.00%	989	989	13
14	Total			$ 99,248			$ 74,804	$ * (24,444)	14

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Progressive Housing, Inc.	100.00%	$ 2,133	$ 2,133	15
16	V	32	Interest	1,564	Progressive Housing, Inc.	100.00%	16,823	15,259	16
17	V	34	Rent		Progressive Housing, Inc.	100.00%	4,718	4,718	17
18	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	556	556	18
19	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,778	1,778	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,564			$ 26,008	$ * 24,444	39

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,089	3Hrs/MTG	1.00	Dir. Fees	$ 511	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,089	3Hrs/MTG	1.00	Dir. Fees	511	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,089	3Hrs/MTG	1.00	Dir. Fees	511	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,089	3Hrs/MTG	1.00	Dir. Fees	511	L18,C8	4
5	Cora Flota	Director	Board Member	None	758	3Hrs/MTG	1.00	Dir. Fees	42	L18,C8	5
6	Edward Copeland	Director	Board Member	None	4,544	3Hrs/MTG	1.00	Dir. Fees	256	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	142,011	1.18	2.95	Salary	7,984	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,326		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
6/30/2012

SCHEDULE 7A

BOARD OF DIRECTOR FEES

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: 3615 Park Drive, Suite 100
City / State / Zip Code: Olympia Fields, IL 60461
Phone Number: (708) 283-1530
Fax Number: (708) 283-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Budgeted Rev/Dir Cost	15,472,003	31	$ 67	$	823,596	$ 4	1
2	5	Utilities	Budgeted Rev/Dir Cost	15,472,003	31	12,706		823,596	676	2
3	6	Maintenance	Budgeted Rev/Dir Cost	15,472,003	31	14,679		823,596	743	3
4	18	Director Fees	Budgeted Rev/Dir Cost	15,472,003	31	44,000		823,596	2,342	4
5	19	Professional Services	Budgeted Rev/Dir Cost	15,472,003	31	182,889		823,596	8,945	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	15,472,003	31	15,420		823,596	1,003	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	15,472,003	31	951,030	896,943	823,596	50,863	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	15,472,003	31	138,267		823,596	7,337	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	15,472,003	31	49,382		823,596	1,404	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	15,472,003	31	14,771		823,596	498	10
11	26	Insurance	Budgeted Rev/Dir Cost	15,472,003	31	20,429		823,596	989	11
12	30	Depreciation	Budgeted Rev/Dir Cost	15,472,003	31	40,101		823,596	2,133	12
13	32	Interest	Budgeted Rev/Dir Cost	15,472,003	31	316,315		823,596	16,823	13
14	34	Rent	Budgeted Rev/Dir Cost	15,472,003	31	137,366		823,596	4,718	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	15,472,003	31	12,925		823,596	556	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	15,472,003	31	40,910		823,596	1,778	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,991,257	$ 896,943		$ 100,812	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 766,870	$ 766,870	08/15/26	6.7500	$ 32,366	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,050	6
7	Allocation from Home Office-Interest										16,165	7
8	Allocation from Home Office-Amortization										658	8
9	TOTAL Facility Related						$ 766,870	$ 766,870			$ 50,239	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(1,564)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,564)	14
15	TOTALS (line 9+line14)						$ 766,870	$ 766,870			$ 48,675	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: 07/01/2011 Ending: 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Christian

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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	13,916	1993	$ 20,000	1
2	Allocated from Home Office			167	2
3	TOTALS	13,916		$ 20,167	3

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1993	1992	$ 406,000	$ 10,093	40	$ 10,093	$	$ 194,483	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	6,700		15			6,700	9
10	Heating Piping			1997	650	43	15	43		628	10
11	Shower			2000	2,266	151	15	151		1,737	11
12	Flooring			2001	548	36	15	36		387	12
13	Water Services Repairs			2004	1,071	72	15	72		577	13
14	Kitchen Coutner Tops			2005	625	41	15	41		304	14
15	Kitchen Cabinets			2005	3,445	230	15	230		1,708	15
16	Kitchen Remodel			2005	1,429	96	15	96		683	16
17	Air Conditioning Repair			2005	1,650	110	15	110		752	17
18	Bathroom Remodel			2006	710	48	15	48		264	18
19	Bedroom Remodel			2007	1,070	72	15	72		333	19
20	Gazebo			2007	1,896	126	15	126		579	20
21	Alarm Repairs			2008	1,875	125	15	125		511	21
22	Heating/ Cooling			2009	1,928	128	15	128		407	22
23	Building Improvements			2009	806	54	15	54		166	23
24	Repair to Water Main			2009	2,083	138	15	138		393	24
25											25
26											26
27											27
28											28
29											29
30	Allocation from Home Office				3,462			2,133	2,133	16,747	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: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 438,214	$ 11,563		$ 13,696	$ 2,133	$ 227,359	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: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 8,940	$ 940	$ 940	$	5-10Yrs	$ 5,706	71
72	Current Year Purchases	270	14	14		5-10Yrs	14	72
73	Fully Depreciated Assets	12,233	274	274		5-10Yrs	12,233	73
74	Allocated From Home Office	14,359						74
75	TOTALS	$ 35,802	$ 1,228	$ 1,228	$		$ 17,953	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	2004 Ford	2004	$ 27,458	$	$	$	5	$ 27,458	76
77	Resident Transportation	2004 Ford	2008	992	198	198		5	826	77
78										78
79	Allocated from Home Office			6,879						79
80	TOTALS			$ 35,329	$ 198	$ 198	$		$ 28,284	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)	$ 529,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,122	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,133	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 273,596	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	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.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				4,718			6
7	TOTAL				$ 4,718 **			7

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

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

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

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

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

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

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

16. Rental Amount for movable equipment: $ 556 Description: Allocated from Home Office - postage machine, copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

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

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39(3)	visits			1,252			1,252	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				4,264		4,264	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			$		$ 1,252	$ 4,264		$ 5,516	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: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,862	$ 2,862	1
2	Cash-Patient Deposits	9,695	9,695	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,327)	178,849	178,849	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,685	1,685	6
7	Other Prepaid Expenses	350	350	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves	127,015	127,015	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 320,456	$ 320,456	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,167	20,167	13
14	Buildings, at Historical Cost	438,214	438,214	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	71,131	71,131	16
17	Accumulated Depreciation (book methods)	(273,596)	(273,596)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Costs	13,776	13,776	22
23	Other(specify): Deposit	602	602	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 270,294	$ 270,294	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 590,750	$ 590,750	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,595	$ 17,595	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,695	9,695	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,216	6,216	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	26,191	26,191	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	1,138	1,138	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 60,835	$ 60,835	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	766,870	766,870	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)**	$ 766,870	$ 766,870	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 827,705	$ 827,705	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (236,955)	$ (236,955)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 590,750	$ 590,750	48

*(See instructions.)

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,513,298	1
2	Restatements (describe):		2
3	**Rounding**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,513,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,831	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)**	$ 99,831	17
	B. Transfers (Itemize):		
18	**Allocation of Progressive Housing, Inc. Balance Sheet**		18
19	**to individual facilities**	(1,850,083)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,850,083)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (236,955)	24 *

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 614,589	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 614,589	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	1,466	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,466	23
	D. Non-Operating Revenue		
24	Contributions	1,155	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,155	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		12,829	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,829	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 630,039	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	92,938	31
32	Health Care	183,370	32
33	General Administration	168,712	33
	B. Capital Expense		
34	Ownership	46,405	34
	C. Ancillary Expense		
35	Special Cost Centers	5,813	35
36	Provider Participation Fee	32,970	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 530,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	99,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 99,831	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 614,589	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)	$ 614,589	49

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

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

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

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

Facility Name Park Place
ID# 0040360
FYE 6/30/2012

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	500	500	5,681	11.36	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	1,830	1,989	16,957	8.53	15
16	Dishwashers					16
17	Maintenance Workers	818	818	7,155	8.75	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	5	23	393	17.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4	6	125	20.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,957	2,114	24,539	11.61	29
30	Habilitation Aides (DD Homes)	14,139	14,999	130,454	8.70	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) QSP	73	73	1,279	17.52	33
34	TOTAL (lines 1 - 33)	19,326	20,522	$ 186,583 *	$ 9.09	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	21	$ 1,668	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	63	1,585	L10, C3	38
39	Pharmacist Consultant	Monthly	646	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	21	1,345	L12, C3	45
46	Other(specify) Psychological Cons.	Monthly	297	L39,C3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	105	$ 10,341		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: 07/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 393
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 393

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 99,240
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,240
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakly Payroll Service	Payroll Service	$ 1,078
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,078

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,158
Unemployment Compensation Insurance	13,318
FICA Taxes	14,404
Employee Health Insurance	8,209
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403B Retirement Contribution	92
Life Insurance	36
Other Employee Benefits	195
Allocated from Home Office	7,337
TOTAL (agree to Schedule V, line 22, col.8)	$ 49,749

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Hiring Expense	61
Miscellaneous Dues & Fees	949
Allocation from Home Office	1,003
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,013

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	344
Allocation from Home Office	1,364
Seminar Expense	8
Allocation from Home Office	40
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,756

**See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,803** 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. $ **32,970**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **99**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold- Banwart, LTD**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	16,957	1,725	1,668	20,350	0	20,350	0	20,350
2. Food Purchase	0	40,005	0	40,005	0	40,005	-8	39,997
3. Housekeeping	0	2,403	0	2,403	0	2,403	4	2,407
4. Laundry	0	1,049	0	1,049	0	1,049	0	1,049
5. Heat and Other Utilities	0	0	15,739	15,739	0	15,739	676	16,415
6. Maintenance	7,155	1,733	4,504	13,392	0	13,392	743	14,135
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	24,112	46,915	21,911	92,938	0	92,938	1,415	94,353
9. Medical Director	0	0	4,800	4,800	0	4,800	0	4,800
10. Nursing & Medical Records	161,953	4,807	2,298	169,058	0	169,058	0	169,058
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	1,286	408	1,694	0	1,694	0	1,694
12. Social Services	0	0	1,345	1,345	0	1,345	0	1,345
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	6,473	6,473	0	6,473	0	6,473
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	161,953	6,093	15,324	183,370	0	183,370	0	183,370
17. Administrative	393	0	99,240	99,633	0	99,633	-99,240	393
18. Directors Fees	0	0	0	0	0	0	2,342	2,342
19. Professional Services	0	0	1,078	1,078	0	1,078	8,945	10,023
20. Fees, Subscriptions & Promotion	0	0	1,010	1,010	0	1,010	1,003	2,013
21. Clerical & General Office	125	3,869	15,549	19,543	0	19,543	50,863	70,406
22. Employee Benefits & Payroll	0	0	42,412	42,412	0	42,412	7,337	49,749
23. Inservice Training & Education	0	0	125	125	0	125	0	125
24. Travel and Seminar	0	0	352	352	0	352	1,404	1,756
25. Other Admin. Staff Trans	0	0	56	56	0	56	498	554
26. Insurance-Prop.Liab.Malpractice	0	0	4,503	4,503	0	4,503	989	5,492
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	518	3,869	164,325	168,712	0	168,712	-25,859	142,853
29. Total General Administrative	186,583	56,877	201,560	445,020	0	445,020	-24,444	420,576
30. Depreciation	0	0	12,989	12,989	0	12,989	2,133	15,122
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	33,416	33,416	0	33,416	15,259	48,675
33. Real Estate	0	0	0	0	0	0	0	0

34.	Rent - Facility & Grounds		0	0	0	0	0	0	4,718	4,718
35.	Rent - Equipment & Vehicles		0	0	0	0	0	0	556	556
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	46,405	46,405	0	46,405	22,666	69,071
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	4,264	1,549	5,813	0	5,813	0	5,813
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	0	0	0	0	0	0	0
		42	0	0	32,970	32,970	0	32,970	0	32,970
43.	Other (specify):*		0	0	0	0	0	0	0	0
44.	Total Special Cost Ce		0	4,264	34,519	38,783	0	38,783	0	38,783
45.	Grand Total		186,583	61,141	282,484	530,208	0	530,208	-1,778	528,430

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,862	2,862
2. Cash - Patient Deposits	9,695	9,695
3. Accounts & Notes Recievable	178,849	178,849
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,685	1,685
7. Other Prepaid Expenses	350	350
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	127,015	127,015
10. Total current assets	320,456	320,456
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,167	20,167
14. Buildings, at Historical Cost	438,214	438,214
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	71,131	71,131
17. Accumulated Depreciation (book methods)	-273,596	-273,596
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	13,776	13,776
23. other (specify):	602	602
24. Total Long-Term Assets	270,294	270,294
25. Total Assets	590,750	590,750
CURRENT LIABILITIES		
26. Accounts Payable	17,595	17,595
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	9,695	9,695
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	6,216	6,216
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	26,191	26,191
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,138	1,138

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	60,835	60,835
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	766,870	766,870
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	766,870	766,870
46.Total Liabilities	827,705	827,705
47.Total Equity	-236,955	-236,955
48.Total Liabilities and Equity	590,750	590,750

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	614,589
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	614,589
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	1,466
22. Laundry	0
Subtotal - Other Operating Revenue	1,466
24. Contributions	1,155
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	1,155
27. Other Revenue (specify):	0
28. Other Revenue (specify):	12,829
Subtotal - Other Revenue	12,829
30. Total Revenue	630,039
31. General Services	92,938
32. Health Care	183,370
33. General Administration	168,712
34. Ownership	46,405

35.	Special Cost Centers	5,813
35.	Provider Participation Fee	32,970
37.	Other	0
40.	Total Expenses	530,208
41.	Income Before Income Taxes	99,831
42.	Income Taxes	0
43.	Net Income or Loss for the Year	99,831