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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2012 to 6/30/13 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) Tracey Peloza
(Title) Chief Financial Officer

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: 7/1/2012 Ending: 6/30/13

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	5,212			5,212	13
14	TOTALS	5,212			5,212	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.25%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	16,479	2,167	1,430	20,076		20,076		20,076			1
2	Food Purchase		31,996		31,996		31,996		31,996			2
3	Housekeeping		1,653		1,653		1,653	11	1,664			3
4	Laundry		1,602		1,602		1,602		1,602			4
5	Heat and Other Utilities			14,098	14,098		14,098	56	14,154			5
6	Maintenance	9,561	670	4,598	14,829		14,829	201	15,030			6
7	Other (specify):*											7
8	TOTAL General Services	26,040	38,088	20,126	84,254		84,254	268	84,522			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	168,743	7,237	3,029	179,009		179,009		179,009			10
10a	Therapy											10a
11	Activities		1,995		1,995		1,995		1,995			11
12	Social Services			962	962		962		962			12
13	CNA Training											13
14	Program Transportation			3,337	3,337		3,337		3,337			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	168,743	9,232	12,128	190,103		190,103		190,103			16
	C. General Administration											
17	Administrative	19,913		98,668	118,581		118,581	(98,668)	19,913			17
18	Directors Fees							2,689	2,689			18
19	Professional Services			1,370	1,370		1,370	11,529	12,899			19
20	Dues, Fees, Subscriptions & Promotions			987	987		987	1,254	2,241			20
21	Clerical & General Office Expenses	1,508	2,319	13,056	16,883		16,883	50,573	67,456			21
22	Employee Benefits & Payroll Taxes			48,607	48,607		48,607	7,155	55,762			22
23	Inservice Training & Education			128	128		128		128			23
24	Travel and Seminar			579	579		579	1,677	2,256			24
25	Other Admin. Staff Transportation			924	924		924	780	1,704			25
26	Insurance-Prop.Liab.Malpractice			16,023	16,023		16,023	684	16,707			26
27	Other (specify):*											27
28	TOTAL General Administration	21,421	2,319	180,342	204,082		204,082	(22,327)	181,755			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	216,204	49,639	212,596	478,439		478,439	(22,059)	456,380			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:** 7/1/2012 **Ending:** 6/30/13

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			12,833	12,833		12,833	1,752	14,585			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,126	33,126		33,126	12,743	45,869			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							5,725	5,725			34
35	Rent-Equipment & Vehicles							1,157	1,157			35
36	Other (specify):*											36
37	**TOTAL Ownership**			45,959	45,959		45,959	21,377	67,336			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		725	463	1,188		1,188		1,188			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,880	36,880		36,880		36,880			42
43	Other (specify):* Non-allowable Costs			4,680	4,680		4,680	(4,680)				43
44	**TOTAL Special Cost Centers**		725	42,023	42,748		42,748	(4,680)	38,068			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	216,204	50,364	300,578	567,146		567,146	(5,362)	561,784			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: 7/1/2012 Ending: 6/30/13

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	(208)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(474)	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	(4,680)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (5,362)		$	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))**	$ (5,362)		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: 7/1/2012

Ending: 6/30/13

	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: 7/1/2012 Ending: 6/30/13

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	3	Housekeeping	$	Progressive Housing, Inc.	100.00%	$ 11	$ 11	1
2	V	5	Utilities		Progressive Housing, Inc.	100.00%	56	56	2
3	V	6	Maintenance		Progressive Housing, Inc.	100.00%	201	201	3
4	V	17	Administrative	98,668	Progressive Housing, Inc.	100.00%		(98,668)	4
5	V	18	Director Fees		Progressive Housing, Inc.	100.00%	2,689	2,689	5
6	V	19	Professional Services		Progressive Housing, Inc.	100.00%	11,529	11,529	6
7	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,254	1,254	7
8	V	21	Clerical and General Office	41	Progressive Housing, Inc.	100.00%	50,614	50,573	8
9	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	7,155	7,155	9
10	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,677	1,677	10
11	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	780	780	11
12	V	26	Insurance		Progressive Housing, Inc.	100.00%	684	684	12
13	V	30	Depreciation		Progressive Housing, Inc.	100.00%	1,752	1,752	13
14	Total			$ 98,709			$ 78,402	$ * (20,307)	14

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	32	Interest	$ 423	Progressive Housing, Inc.	100.00%	$ 13,166	$ 12,743	15
16	V	34	Rent		Progressive Housing, Inc.	100.00%	5,725	5,725	16
17	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	1,157	1,157	17
18	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	682	682	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			$ 423			$ 20,730	$ * 20,307	39

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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			Ellner Terrace	Evansville	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			Aviston Terrace	Aviston	& 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: 7/1/2012 Ending: 6/30/13

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	9,145	3Hrs/MTG	1.00	Dir. Fees	$ 455	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,146	3Hrs/MTG	1.00	Dir. Fees	454	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,146	3Hrs/MTG	1.00	Dir. Fees	454	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,146	3Hrs/MTG	1.00	Dir. Fees	454	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,383	3Hrs/MTG	1.00	Dir. Fees	417	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,145	3Hrs/MTG	1.00	Dir. Fees	455	L18,C8	6
7	Lawrence Manson	President	CEO / Board Mem	None	170,663	1.18	2.95	Salary	8,379	L21,C7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,068		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
6/30/2013
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	446	410	446	447	447	447	2,643	8,237
Ellner Terrace	464	425	464	463	463	463	2,742	8,559
Taylorville Terrace	519	475	519	518	518	518	3,067	9,597
Aviston Terrace	484	444	484	483	483	483	2,861	8,880
Briarbrook Place	534	490	534	535	535	535	3,163	9,847
Harris Place	516	474	516	517	517	517	3,057	9,579
Joshua Manor	462	425	462	463	463	463	2,738	8,469
Terra Estates	476	437	476	475	475	475	2,814	8,701
Park Place	455	417	455	454	454	454	2,689	8,379
Western Gardens	210	194	211	211	211	211	1,248	3,957
Galaxy	277	254	277	277	277	277	1,639	5,246
Cardinal	181	165	180	180	180	180	1,066	3,348
Bill Goat Hill	248	228	248	249	249	249	1,471	4,673
Country Club Hill	202	186	202	203	203	203	1,199	3,831
Lee Street	219	200	219	219	219	219	1,295	4,190
Baker Street	178	163	178	178	178	178	1,053	3,348
182nd Street	215	197	215	215	215	215	1,272	4,064
Osage	195	178	195	196	196	196	1,156	3,670
Oakwood	219	200	218	218	218	218	1,291	4,118
Blair	242	222	241	242	242	242	1,431	4,601
Lowell	236	217	236	237	237	237	1,400	4,440
Marquette	249	228	248	248	248	248	1,469	4,691
Cherry	234	214	234	234	234	234	1,384	4,422
Luella	302	277	302	303	303	303	1,790	5,819
Olivia	315	288	315	316	316	316	1,866	5,890
Huron	228	209	227	227	227	227	1,345	4,297
Wilshire	246	225	247	246	246	246	1,456	4,637
Constance	148	135	149	148	148	147	875	2,686
175th Place	271	248	272	271	270	271	1,603	5,121

Sauganash	0	0	0	0	0	0	0	0
Steger	417	383	417	416	417	417	2,467	7,824
Waltonville	36	31	36	35	35	35	208	3,921
Mt. Vernon	176	161	177	176	176	176	1,042	0
Total PHI	9,600	8,800	9,600	9,600	9,600	9,600	56,800	179,042

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	13,188,353	31	$ 237	$	617,210	$ 11	1
2	5	Utilities	Budgeted Rev/Dir Cost	13,188,353	31	1,184		617,210	56	2
3	6	Maintenance	Budgeted Rev/Dir Cost	13,188,353	31	6,456		617,210	201	3
4	18	Director Fees	Budgeted Rev/Dir Cost	13,188,353	31	56,800		617,210	2,689	4
5	19	Professional Services	Budgeted Rev/Dir Cost	13,188,353	31	233,624		617,210	11,529	5
6	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	13,188,353	31	27,886		617,210	1,254	6
7	21	Clerical and General Office	Budgeted Rev/Dir Cost	13,188,353	31	1,068,896	964,998	617,210	50,614	7
8	22	Employee Benefits	Budgeted Rev/Dir Cost	13,188,353	31	151,773		617,210	7,155	8
9	24	Travel and Seminar	Budgeted Rev/Dir Cost	13,188,353	31	41,254		617,210	1,677	9
10	25	Auto Expense	Budgeted Rev/Dir Cost	13,188,353	31	19,131		617,210	780	10
11	26	Insurance	Budgeted Rev/Dir Cost	13,188,353	31	14,561		617,210	684	11
12	30	Depreciation	Budgeted Rev/Dir Cost	13,188,353	31	37,448		617,210	1,752	12
13	32	Interest	Budgeted Rev/Dir Cost	13,188,353	31	281,328		617,210	13,166	13
14	34	Rent	Budgeted Rev/Dir Cost	13,188,353	31	119,600		617,210	5,725	14
15	35	Equipment Rental	Budgeted Rev/Dir Cost	13,188,353	31	31,048		617,210	1,157	15
16	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	13,188,353	31	63,622		617,210	682	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,154,848	$ 964,998		$ 99,132	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	$ 680,152	08/15/26	6.7500	$ 32,081	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,045	6
7	Allocation from Home Office-Interest										12,587	7
8	Allocation from Home Office-Amortization										579	8
9	TOTAL Facility Related						$ 766,870	$ 680,152			$ 46,292	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(423)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (423)	14
15	TOTALS (line 9+line14)						$ 766,870	$ 680,152			$ 45,869	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:** 7/1/2012 **Ending:** 6/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)	**2012**	$ **N/A**	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 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:			
	2008		**8**
	2009		**9**
	2010		**10**
	2011		**11**
	2012		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	**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.

2012 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 2012 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 2012.

	(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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 7/1/2012 Ending: 6/30/13

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:

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			147	2
3	TOTALS	13,916		$ 20,147	3

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	$ 10,150	40	$ 10,150	$	$ 204,633	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	22	15	22		650	10
11	Shower			2000	2,266	151	15	151		1,888	11
12	Flooring			2001	548	36	15	36		423	12
13	Water Services Repairs			2004	1,071	72	15	72		649	13
14	Kitchen Coutner Tops			2005	625	41	15	41		345	14
15	Kitchen Cabinets			2005	3,445	230	15	230		1,938	15
16	Kitchen Remodel			2005	1,429	96	15	96		779	16
17	Air Conditioning Repair			2005	1,650	110	15	110		862	17
18	Bathroom Remodel			2006	710	48	15	48		312	18
19	Bedroom Remodel			2007	1,070	72	15	72		405	19
20	Gazebo			2007	1,896	126	15	126		705	20
21	Alarm Repairs			2008	1,875	125	15	125		636	21
22	Heating/ Cooling			2009	1,928	128	15	128		535	22
23	Building Improvements			2009	806	54	15	54		220	23
24	Repair to Water Main			2009	2,083	138	15	138		531	24
25	Damper			2013	597	5	10	5		5	25
26											26
27											27
28											28
29											29
30	Allocation from Home Office				3,046			130	130	574	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: 7/1/2012 Ending: 6/30/13

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)		$ 438,395	$ 11,604		$ 11,734	$ 130	$ 222,790	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: 7/1/2012 Ending: 6/30/13

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	$ 8,488	$ 742	$ 742	$	5-10Yrs	$ 6,070	71
72	Current Year Purchases	2,758	261	261		5-10Yrs	261	72
73	Fully Depreciated Assets	12,685	60	60		5-10Yrs	12,685	73
74	Allocated From Home Office	12,890		1,330	1,330		10,001	74
75	TOTALS	$ 36,821	$ 1,063	$ 2,393	$ 1,330		$ 29,017	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	166	166		5	992	77
78										78
79	Allocated from Home Office			6,066		292	292		5,698	79
80	TOTALS			$ 34,516	$ 166	$ 458	$ 292		$ 34,148	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)	$ 529,879	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,833	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 14,585	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,752	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 285,955	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: 7/1/2012 Ending: 6/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from Home Office			5,725			6
7	TOTAL				$ 5,725 **			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
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 1,157 Description: Allocated from Home Office - postage machine, copier, storage
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	39(3)	visits		14	265		14	265	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				725		725	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39(3)	hrs		2	198		2	198	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	16	$ 463	$ 725	16	$ 1,188	14

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13 (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	$ 51,277	$ 51,277	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,366)	117,272	117,272	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,399	2,399	6
7	Other Prepaid Expenses	1,420	1,420	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves/Deposits	89,734	89,734	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 262,102	$ 262,102	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,147	13
14	Buildings, at Historical Cost	435,349	438,395	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	52,381	71,337	16
17	Accumulated Depreciation (book methods)	(269,684)	(285,955)	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	8,552	8,552	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 246,598	$ 252,476	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 508,700	$ 514,578	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 11,609	$ 11,609	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,657	14,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,182	1,182	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	13,893	13,893	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	2,258	2,258	36
37	Deposits/Deferred Income	2,005	2,005	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 45,604	$ 45,604	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	680,152	680,152	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)**	$ 680,152	$ 680,152	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 725,756	$ 725,756	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (217,056)	$ (211,178)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 508,700	$ 514,578	48

*(See instructions.)

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (236,955)	1
2	Restatements (describe):		2
3	**Rounding**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (236,955)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,908	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)**	$ 36,908	17
	B. Transfers (Itemize):		
18	**Allocation of Progressive Housing, Inc. Balance Sheet**		18
19	**to individual facilities**	(17,009)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (17,009)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (217,056)	24 *

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	$ 597,426	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 597,426	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	5,419	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)**	$ 5,419	23
	D. Non-Operating Revenue		
24	Contributions	1,209	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,209	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)**	$ 604,054	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	84,254	31
32	Health Care	190,103	32
33	General Administration	204,082	33
	B. Capital Expense		
34	Ownership	45,959	34
	C. Ancillary Expense		
35	Special Cost Centers	5,868	35
36	Provider Participation Fee	36,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 567,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	36,908	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 36,908	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 597,426	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)	$ 597,426	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 6/30/2013

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: 7/1/2012 Ending: 6/30/13

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	538	552	6,242	11.31	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	1,934	16,479	8.52	15
16	Dishwashers					16
17	Maintenance Workers	1,049	1,106	9,561	8.64	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	958	1,127	19,913	17.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	68	73	1,508	20.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,816	2,094	23,823	11.38	29
30	Habilitation Aides (DD Homes)	14,852	15,887	138,678	8.73	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,962	22,773	$ 216,204 *	$ 9.49	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	20	$ 1,166	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant			L10, C3	37
38	Nurse Consultant	90	2,244	L10, C3	38
39	Pharmacist Consultant	Monthly	785	L10, C3	39
40	Physical Therapy Consultant			L10a, C3	40
41	Occupational Therapy Consultant			L10a, C3	41
42	Respiratory Therapy Consultant			L10a, C3	42
43	Speech Therapy Consultant			L10a, C3	43
44	Activity Consultant			L11, C3	44
45	Social Service Consultant	17	962	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	127	$ 9,957		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: 7/1/2012 Ending: 6/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 19,913
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 19,913

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 98,668
TOTAL (agree to Schedule V, line 17, col. 3)	$ 98,668
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakly Payroll Service	Payroll Service	$ 1,370
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,370

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	15,452
FICA Taxes	16,365
Employee Health Insurance	10,304
Employee Meals	5,214
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	41
Other Employee Benefits	1,231
Allocated from Home Office	7,155
TOTAL (agree to Schedule V, line 22, col.8)	$ 55,762

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	
Health Care Worker Background Check	
(Indicate # of checks performed 17)	171
Patient Background Checks	
Hiring Expense	723
Miscellaneous Dues & Fees	93
Allocated from Home Office	1,254
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	579
Allocated from Home Office	1,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,256

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2012 Ending: 6/30/13

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. $ **3,193** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,880**
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. $ **5,214** 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? **78**
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 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.