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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: Larry Templin **Telephone Number:** 630-361-2868
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 7/1/2014 to 6/30/2015 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) Jessica Rosales
(Title) Chief Operating Officer

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

III. STATISTICAL DATA

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

	1 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	5,056			5,056	13
14	TOTALS	5,056			5,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.58%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] 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 [ ] 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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	15,151	1,804	1,304	18,259		18,259		18,259			1
2	Food Purchase		27,045		27,045		27,045		27,045			2
3	Housekeeping		1,397		1,397		1,397		1,397			3
4	Laundry		1,951		1,951		1,951		1,951			4
5	Heat and Other Utilities			14,750	14,750		14,750	43	14,793			5
6	Maintenance	9,352	753	7,053	17,158		17,158	32	17,190			6
7	Other (specify):*											7
8	TOTAL General Services	24,503	32,950	23,107	80,560		80,560	75	80,635			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	196,982	6,942	4,864	208,788		208,788		208,788			10
10a	Therapy											10a
11	Activities		1,603		1,603		1,603		1,603			11
12	Social Services			1,458	1,458		1,458		1,458			12
13	CNA Training											13
14	Program Transportation			2,584	2,584		2,584		2,584			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	196,982	8,545	13,706	219,233		219,233		219,233			16
	C. General Administration											
17	Administrative	9,907		103,040	112,947		112,947	(103,040)	9,907			17
18	Directors Fees							3,080	3,080			18
19	Professional Services			4,042	4,042		4,042	8,672	12,714			19
20	Dues, Fees, Subscriptions & Promotions			1,371	1,371		1,371	3,422	4,793			20
21	Clerical & General Office Expenses	2,507	2,175	15,932	20,614		20,614	58,843	79,457			21
22	Employee Benefits & Payroll Taxes			59,885	59,885		59,885	8,107	67,992			22
23	Inservice Training & Education			372	372		372		372			23
24	Travel and Seminar			567	567		567	1,204	1,771			24
25	Other Admin. Staff Transportation			2,217	2,217		2,217	683	2,900			25
26	Insurance-Prop.Liab.Malpractice			6,384	6,384		6,384	216	6,600			26
27	Other (specify):*											27
28	TOTAL General Administration	12,414	2,175	193,810	208,399		208,399	(18,813)	189,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	233,899	43,670	230,623	508,192		508,192	(18,738)	489,454			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:** 7/1/2014 **Ending:** 6/30/2015

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			14,165	14,165		14,165	1,667	15,832			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,227	29,227		29,227	11,243	40,470			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							1,469	1,469			35
36	Other (specify):*											36
37	**TOTAL Ownership**			43,392	43,392		43,392	14,379	57,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,281		3,281		3,281		3,281			39
40	Barber and Beauty Shops			40	40		40		40			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,561	34,561		34,561		34,561			42
43	Other (specify):* Disallowed Costs			4,151	4,151		4,151	(4,151)				43
44	**TOTAL Special Cost Centers**		3,281	38,752	42,033		42,033	(4,151)	37,882			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	233,899	46,951	312,767	593,617		593,617	(8,510)	585,107			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(20)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,131)	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 pg 5A	(4,359)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,510)		$	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))**	$ (8,510)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Park Place

ID# 0040360

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO costs	$ (2,943)	43	1
2	Offset rental income against expense	(1,416)	34	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**	(4,359)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	43	0	0	0	0	0	0	0	0	0	43	5
6	Maintenance	0	32	0	0	0	0	0	0	0	0	0	32	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	75	0	0	0	0	0	0	0	0	0	75	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	(103,040)	0	0	0	0	0	0	0	0	0	(103,040)	17
18	Directors Fees	0	3,080	0	0	0	0	0	0	0	0	0	3,080	18
19	Professional Services	0	8,672	0	0	0	0	0	0	0	0	0	8,672	19
20	Fees, Subscriptions & Promotions	0	3,422	0	0	0	0	0	0	0	0	0	3,422	20
21	Clerical & General Office Expenses	0	58,843	0	0	0	0	0	0	0	0	0	58,843	21
22	Employee Benefits & Payroll Taxes	0	8,107	0	0	0	0	0	0	0	0	0	8,107	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,204	0	0	0	0	0	0	0	0	0	1,204	24
25	Other Admin. Staff Transportation	0	683	0	0	0	0	0	0	0	0	0	683	25
26	Insurance-Prop.Liab.Malpractice	0	216	0	0	0	0	0	0	0	0	0	216	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(18,813)	0	0	0	0	0	0	0	0	0	(18,813)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(18,738)	0	0	0	0	0	0	0	0	0	(18,738)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,667	0	0	0	0	0	0	0	0	0	1,667	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,243	0	0	0	0	0	0	0	0	0	11,243	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,416)	0	1,416	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,469	0	0	0	0	0	0	0	0	1,469	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,416)	12,910	2,885	0	0	0	0	0	0	0	0	14,379	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):*	(7,094)	0	2,943	0	0	0	0	0	0	0	0	(4,151)	43
44	**TOTAL Special Cost Centers**	(7,094)	0	2,943	0	0	0	0	0	0	0	0	(4,151)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,510)	(5,828)	5,828	0	0	0	0	0	0	0	0	(8,510)	45

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	17	Administrative	$ 103,040	Progressive Housing, Inc.	100.00%	$	$ (103,040)	1
2	V	5	Utilities		Progressive Housing, Inc.	100.00%	43	43	2
3	V	6	Maintenance		Progressive Housing, Inc.	100.00%	32	32	3
4	V	18	Director Fees		Progressive Housing, Inc.	100.00%	3,080	3,080	4
5	V	19	Professional Services		Progressive Housing, Inc.	100.00%	8,672	8,672	5
6	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,422	3,422	6
7	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	58,843	58,843	7
8	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	8,107	8,107	8
9	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,204	1,204	9
10	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	683	683	10
11	V	26	Insurance		Progressive Housing, Inc.	100.00%	216	216	11
12	V	30	Depreciation		Progressive Housing, Inc.	100.00%	1,667	1,667	12
13	V	32	Interest		Progressive Housing, Inc.	100.00%	11,243	11,243	13
14	Total			$ 103,040			$ 97,212	$ * (5,828)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	34	Rent		Progressive Housing, Inc.	100.00%	$ 1,416	$ 1,416	15
16	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	1,469	1,469	16
17	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	2,943	2,943	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			$			$ 5,828	$ * 5,828	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	9,162	3Hrs/MTG	1.00	Dir. Fees	$ 438	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,162	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	7,635	3Hrs/MTG	1.00	Dir. Fees	365	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,399	3Hrs/MTG	1.00	Dir. Fees	401	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,162	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,162	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	5,345	3Hrs/MTG	1.00	Dir. Fees	255	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,773		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Park Place
0040360
6/30/2015

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Cora Flota	Edward Childers	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Eileen Mullin	Misc Exp	Total
Sparta Terrace	366	366	366	366	305	335	213	263	2,579
Ellner Terrace	459	459	459	459	382	421	268	321	3,227
Taylorville Terrace	465	465	465	465	387	426	271	324	3,267
Aviston Terrace	397	397	397	397	331	364	232	282	2,799
Briarbrook Place	466	466	466	466	388	427	272	325	3,274
Harris Place	427	427	427	427	356	392	249	301	3,007
Joshua Manor	367	367	367	367	306	336	214	262	2,585
Terra Estates	442	442	442	442	368	405	258	310	3,107
Park Place	438	438	438	438	365	401	255	308	3,080
Western Gardens	236	236	236	236	197	216	138	162	1,658
Galaxy	273	273	273	273	227	250	159	187	1,914
Cardinal	204	204	204	204	170	187	119	144	1,433
Bill Goat Hill	249	249	249	249	207	228	145	172	1,747
Country Club Hill	214	214	214	214	178	196	125	147	1,503
Lee Street	267	267	267	267	222	245	156	180	1,870
Baker Street	205	205	205	205	171	188	120	141	1,442
182nd Street	228	228	228	228	190	209	133	156	1,603
Osage	189	189	189	189	158	173	110	131	1,329
Oakwood	220	220	220	220	183	202	128	151	1,543
Blair	305	305	305	305	254	280	178	209	2,142
Lowell	267	267	267	267	222	245	156	182	1,872
Marquette	247	247	247	247	206	226	144	169	1,732
Cherry	234	234	234	234	195	215	137	159	1,643
Luella	220	220	220	220	183	202	128	155	1,547
Olivia	310	310	310	310	258	284	181	209	2,173
Huron	228	228	228	228	190	209	133	156	1,603
Wilshire	269	269	269	269	224	246	157	184	1,886

Constance	236	236	236	236	197	216	138	162	1,658
175th Place	270	270	270	270	225	247	157	184	1,892
Sauganash	-	-	-	-	-	-	-	10	10
Steger	510	510	510	510	425	467	297	337	3,565
Waltonville	194	194	194	194	162	178	113	129	1,357
Mt. Vernon	200	200	200	200	166	183	116	135	1,400
Total BOD Expense	**9,600**	**9,600**	**9,600**	**9,600**	**8,000**	**8,800**	**5,600**	**6,647**	**67,447**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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: 20180 Governors Dr., Suite 300
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	5	Utilities	Budgeted Rev/Dir Cost	13,171,654	33	939		544,919	$ 43	1
2	6	Maintenance	Budgeted Rev/Dir Cost	13,171,654	33	701		544,919	32	2
3	18	Director Fees	Budgeted Rev/Dir Cost	13,171,654	33	67,447		544,919	3,080	3
4	19	Professional Services	Budgeted Rev/Dir Cost	13,171,654	33	204,232		544,919	8,672	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	13,171,654	33	74,328		544,919	3,422	5
6	21	Clerical and General Office	Budgeted Rev/Dir Cost	13,171,654	33	1,291,500	1,101,919	544,919	58,843	6
7	22	Employee Benefits	Budgeted Rev/Dir Cost	13,171,654	33	178,040		544,919	8,107	7
8	24	Travel and Seminar	Budgeted Rev/Dir Cost	13,171,654	33	27,459		544,919	1,204	8
9	25	Auto Expense	Budgeted Rev/Dir Cost	13,171,654	33	14,968		544,919	683	9
10	26	Insurance	Budgeted Rev/Dir Cost	13,171,654	33	8,530		544,919	216	10
11	30	Depreciation	Budgeted Rev/Dir Cost	13,171,654	33	36,018		544,919	1,667	11
12	32	Interest	Budgeted Rev/Dir Cost	13,171,654	33	238,933		544,919	11,243	12
13	34	Rent	Budgeted Rev/Dir Cost	13,171,654	33	31,050		544,919	1,416	13
14	35	Equipment Rental	Budgeted Rev/Dir Cost	13,171,654	33	40,919		544,919	1,469	14
15	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	13,171,654	33	281,423		544,919	2,943	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,496,487	$ 1,101,919		$ 103,040	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 599,570	08/15/26	6.7500	$ 28,205	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,022	6
7	Allocation from Home Office-Interest										10,739	7
8	Allocation from Home Office-Amortization										564	8
9	TOTAL Facility Related						$ 766,870	$ 599,570			$ 40,530	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(60)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (60)	14
15	TOTALS (line 9+line14)						$ 766,870	$ 599,570			$ 40,470	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** 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: 7/1/2014 Ending: 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

N/A - Not for profit entity.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 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 2014 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 2014.

	(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 X _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 7/1/2014 Ending: 6/30/2015

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			4,774	2
3	TOTALS	13,916		$ 24,774	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$	$ 224,933	4
5				2013	(15,586)	(390)	40	(390)		(8,288)	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1995	6,700		15			6,700	9
10	Heating Piping			1997	650		15			650	10
11	Shower-disposed			2000		63	15	63			11
12	Flooring			2001	548	37	15	37		496	12
13	Water Services Repairs			2004	1,071	71	15	71		792	13
14	Kitchen Coutner Tops			2005	625	41	15	41		427	14
15	Kitchen Cabinets			2005	3,445	230	15	230		2,398	15
16	Kitchen Remodel			2005	1,429	95	15	95		970	16
17	Air Conditioning Repair			2005	1,650	110	15	110		1,082	17
18	Bathroom Remodel-disposed			2006		25	15	25			18
19	Bedroom Remodel-disposed			2007		30	15	30			19
20	Gazebo			2007	1,896	126	15	126		957	20
21	Alarm Repairs			2008	1,875	125	15	125		886	21
22	Heating/ Cooling			2009	1,928	129	15	129		792	22
23	Building Improvements			2009	806	54	15	54		328	23
24	Repair to Water Main			2009	2,083	139	15	139		808	24
25	Damper			2013	597	60	10	60		125	25
26	Air Conditioner			2014	2,410	161	15	161		174	26
27	Replace Roof (Gross of Write off of Old Roof-See Line 5)			2014	22,283	891	25	891		1,114	27
28	Remodel 2 Bathrooms - repair and replace walls and door frames			2014	9,311	389	15	389		389	28
29	new shower pan and tile surround; new plumbing and sinks,										29
30	flooring, toilets, grab bars and mirrors, new trim and paint										30
31	Replace coil for 4 ton AC unit			2014	795	9	15	9		9	31
32											32
33											33
34	Allocation from Home Office				17,112			404	404	1,027	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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)		$ 467,628	$ 12,545		$ 12,949	$ 404	$ 236,769	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 7/1/2014 Ending: 6/30/2015

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	$ 17,034	$ 1,570	$ 1,570	$	5-10Yrs	$ 5,540	71
72	Current Year Purchases	1,190	50	50		10 Yrs	50	72
73	Fully Depreciated Assets	15,369				5-10Yrs	15,369	73
74	Allocated from Home Office	14,951		1,000	1,000		10,505	74
75	TOTALS	$ 48,544	$ 1,620	$ 2,620	$ 1,000		$ 31,464	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				5	992	77
78										78
79	Allocated from Home Office			6,244		263	263		5,480	79
80	TOTALS			$ 34,694	$	$ 263	$ 263		$ 33,930	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)	$ 575,640	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 14,165	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,832	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,667	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 302,163	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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		Allocated from Home Office			1,416			5
6		Offset rental income			(1,416)			6
7	TOTAL				$ **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 1,469 Description: Allocated from Home Office - postage machine $72, copier $968, storage $429
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				3,281		3,281	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			$		$	$ 3,281		$ 3,281	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015 (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	$ 32,154	$ 32,154	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,490)	30,423	30,423	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,180	2,180	7
8	Accounts Receivable (owners or related parties)	41,014	41,014	8
9	Other(specify): Reserves/Deposits	80,314	80,314	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 186,085	$ 186,085	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	24,774	13
14	Buildings, at Historical Cost	450,516	467,628	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	62,043	83,238	16
17	Accumulated Depreciation (book methods)	(285,583)	(302,163)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Costs	5,215	5,215	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 252,191	$ 278,692	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 438,276	$ 464,777	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,196	$ 9,196	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,808	15,808	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,784	2,784	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,246	11,246	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	7,185	7,185	36
37	Deposits/Deferred Income	942	942	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 47,161	$ 47,161	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	599,570	599,570	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)**	$ 599,570	$ 599,570	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 646,731	$ 646,731	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (208,455)	$ (181,954)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 438,276	$ 464,777	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Park Place **#** 0040360 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (207,240)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (207,240)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,215)	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)**	$ (1,215)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (208,455)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 572,593	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 572,593	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	14,574	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,574	23
	D. Non-Operating Revenue		
24	Contributions	2,976	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,976	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	2,259	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,259	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 592,402	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	80,560	31
32	Health Care	219,233	32
33	General Administration	208,399	33
	B. Capital Expense		
34	Ownership	43,392	34
	C. Ancillary Expense		
35	Special Cost Centers	7,472	35
36	Provider Participation Fee	34,561	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 593,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,215)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,215)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 572,593	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)	$ 572,593	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

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: 7/1/2014 Ending: 6/30/2015

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	53	63	1,418	22.51	3
4	Licensed Practical Nurses	840	891	12,269	13.77	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	1,638	1,820	15,151	8.32	15
16	Dishwashers					16
17	Maintenance Workers	1,000	1,077	9,352	8.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	291	317	9,907	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	63	65	2,507	38.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13	23	548	23.83	28
29	Resident Services Coordinator	1,845	2,077	27,258	13.12	29
30	Habilitation Aides (DD Homes)	16,566	17,332	155,489	8.97	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,309	23,665	$ 233,899 *	$ 9.88	34

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	27	$ 1,304	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	126	3,197	L10, C3	38
39	Pharmacist Consultant	Monthly	1,025	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	27	1,458	L12, C3	45
46	Other(specify) Dental	8	642	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	188	$ 12,426		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 9,907
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 9,907

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 103,040
TOTAL (agree to Schedule V, line 17, col. 3)	$ 103,040
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sheakley Payroll Service	Payroll Service	$ 3,436
Paychex	Payroll Service	606
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 4,042

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,532
Unemployment Compensation Insurance	14,263
FICA Taxes	17,510
Employee Health Insurance	4,994
Employee Meals	4,543
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	34
Other Employee Benefits	9
Allocated from Home Office	8,107
TOTAL (agree to Schedule V, line 22, col.8)	$ 67,992

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 3)	105
Patient Background Checks	
Hiring Expense	890
Miscellaneous Dues & Fees	376
Allocated from Home Office	3,422
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,793

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	567
Allocated from Home Office	1,204
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,771

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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? **No** If YES, what is the capacity? **N/A**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,261** 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. $ **34,561**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **4,543** 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? **48**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.