

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,498			4,498	13
14	TOTALS	4,498			4,498	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.81%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park Place

#0040360

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,403	14,403		14,403	2,519	16,922			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,232	30,232		30,232	14,344	44,576			32
33	Real Estate Taxes			3,716	3,716		3,716	(3,716)				33
34	Rent-Facility & Grounds			56	56		56	(56)				34
35	Rent-Equipment & Vehicles							2,030	2,030			35
36	Other (specify):*											36
37	TOTAL Ownership			48,407	48,407		48,407	15,121	63,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,682		1,682		1,682		1,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,355	34,355		34,355		34,355			42
43	Other (specify):* Disallowed Costs			1,565	1,565		1,565	(1,565)				43
44	TOTAL Special Cost Centers		1,682	35,920	37,602		37,602	(1,565)	36,037			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	238,131	41,054	512,082	791,267		791,267	(180,109)	611,158			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,565)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(178,544)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (180,109)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (180,109)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

Park Place
 ID# 0040360
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 Ending: 6/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallowed HO Costs	\$ (174,772)	43	1
2	Offset rental income against expense	(56)	34	2
3	Disallow Real Estate Taxes	(3,716)	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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	(178,544)		49

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Report Period Beginning:

7/1/2015

Ending:

6/30/2016

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5 Utilities	\$	Progressive Housing, Inc.	100.00%	\$ 3	\$	3	1
2	V	6 Maintenance		Progressive Housing, Inc.	100.00%	15		15	2
3	V	17 Administrative	295,125	Progressive Housing, Inc.	100.00%			(295,125)	3
4	V	18 Director Fees		Progressive Housing, Inc.	100.00%	4,390		4,390	4
5	V	19 Professional Services		Progressive Housing, Inc.	100.00%	10,403		10,403	5
6	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,869		2,869	6
7	V	21 Clerical and General Office	14	Progressive Housing, Inc.	100.00%	70,114		70,100	7
8	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	10,883		10,883	8
9	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,489		1,489	9
10	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	995		995	10
11	V	26 Insurance		Progressive Housing, Inc.	100.00%	313		313	11
12	V	30 Depreciation		Progressive Housing, Inc.	100.00%	2,519		2,519	12
13	V	32 Interest	54	Progressive Housing, Inc.	100.00%	14,398		14,344	13
14	Total		\$ 295,193			\$ 118,391	\$ *	(176,802)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							15
16	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	2,030	2,030	16
17	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	174,772	174,772	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		\$			\$ 176,802	\$ * 176,802	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park Place

0040360

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7/1/2015

Ending:

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			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-closed	Hoyleton	Progressive Careers			7
8			Aviston Terrace	Aviston	& Housing	Mt Vernon	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # **0040360** Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	\$ 569	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,983		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Park Place
0040360
6/30/2016

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2015 Ending: 5/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed Capacity/Specific Alloc.	270	29	47	16	\$ 3	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	270	29	258	16	15	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	270	29	74,216	16	4,390	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	270	29	180,145	16	10,403	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	270	29	49,923	16	2,869	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	270	29	1,229,303	16	70,114	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	270	29	193,338	16	10,883	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	270	29	27,210	16	1,489	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	270	29	17,338	16	995	9
10	26	Insurance	Bed Capacity/Specific Alloc.	270	29	7,498	16	313	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	270	29	43,850	16	2,519	11
12	32	Interest	Bed Capacity/Specific Alloc.	270	29	250,479	16	14,398	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	270	29	41,954	16	2,030	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	270	29	4,719,330	16	174,772	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 6,834,889	\$ 1,076,524	\$ 295,193	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 766,870	\$ 648,325	08/15/26	6.7500	\$ 29,127	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Amortization										1,105	6								
7	Allocation from Home Office-Interest										13,669	7								
8	Allocation from Home Office-Amortization										729	8								
9	TOTAL Facility Related						\$ 766,870	\$ 648,325			\$ 44,630	9								
B. Non-Facility Related*																				
10												10								
11												11								
12									Interest Income Offset-HO		(54)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (54)	14								
15	TOTALS (line 9+line14)						\$ 766,870	\$ 648,325			\$ 44,576	15								

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0040360

CONTACT PERSON REGARDING THIS REPORT Lawrence Manson

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Park Place

0040360 Report Period Beginning:

7/1/2015 Ending:

6/30/2016

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? (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? (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>13,916</u>	<u>1993</u>	<u>\$ 20,000</u>	<u>1</u>
2	<u>Allocated from Home Office</u>			<u>6,657</u>	<u>2</u>
3	TOTALS	13,916		\$ 26,657	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1993	1992	\$ 406,000 *	\$ 10,150	40	\$ 10,150	\$	\$ 235,083	4
5			2013	(15,586)	(390)	40	(390)		(8,678)	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			15				11
12	Flooring		2001	548	37	15	37		533	12
13	Water Services Repairs		2004	1,071	71	15	71		863	13
14	Kitchen Coutner Tops		2005	625	41	15	41		468	14
15	Kitchen Cabinets		2005	3,445	230	15	230		2,628	15
16	Kitchen Remodel		2005	1,429	95	15	95		1,065	16
17	Air Conditioning Repair		2005	1,650	110	15	110		1,192	17
18	Bathroom Remodel-disposed		2006			15				18
19	Bedroom Remodel-disposed		2007			15				19
20	Gazebo		2007	1,896	126	15	126		1,083	20
21	Alarm Repairs		2008	1,875	125	15	125		1,011	21
22	Heating/ Cooling		2009	1,928	129	15	129		921	22
23	Building Improvements		2009	806	54	15	54		382	23
24	Repair to Water Main		2009	2,083	139	15	139		947	24
25	Damper		2013	597	60	10	60		185	25
26	Air Conditioner		2014	2,410	161	15	161		335	26
27	Replace Roof (Gross of Write off of Old Roof-See Line 5)		2014	22,283	891	25	891		2,005	27
28	Remodel 2 Bathrooms - repair and replace walls and door frames		2014	9,311	621	15	621		1,010	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	53	15	53		62	31
32										32
33										33
34	Allocation from Home Office			10,973			450	450		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' PREPARATION REPORT

Facility Name & ID Number Park Place

0040360

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	461,489	\$	12,703	\$	13,153	\$	450	\$	248,445	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$ 15,191	\$ 1,652	\$ 1,652	\$	5-10 Yrs	\$ 4,676	71
72	Current Year Purchases	538	22	22		10 Yrs	22	72
73	Fully Depreciated Assets	17,961	26	26		5-10 Yrs	17,961	73
74	Allocated from Home Office	21,506		1,687	1,687		16,676	74
75	TOTALS	\$ 55,196	\$ 1,700	\$ 3,387	\$ 1,687		\$ 39,335	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			551		382	382			79
80	TOTALS			\$ 29,001	\$	\$ 382	\$ 382		\$ 28,450	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)	\$ 572,343	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,922	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,519	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 316,230	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Park Place

0040360

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5					56			5
6					(56)			6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

N/A

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 2,030 Description: Allocated from Home Office - postage machine \$88, copier \$1,268, storage \$674

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescripts				1,682		1,682	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$ 1,682		\$ 1,682	14	

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 7/1/2015

Ending:

6/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2016

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 62,437	\$ 62,437	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 25,185)	66,165	66,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)	8,275	8,275	8
9	Other(specify): <u>Reserves/Deposits</u>	78,318	78,318	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 220,906	\$ 220,906	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,657	13
14	Buildings, at Historical Cost	39,500	461,489	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	36,820	84,197	16
17	Accumulated Depreciation (book methods)	(22,210)	(316,230)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Loan Costs</u>	5,792	5,792	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 79,902	\$ 261,905	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 300,808	\$ 482,811	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,811	\$ 16,811	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,501	24,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,614	1,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,292	15,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	16,939	16,939	36
37	<u>Deposits/Deferred Income</u>	898	898	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 76,055	\$ 76,055	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	648,325	648,325	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Bond Fund</u>	65,285	65,285	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 713,610	\$ 713,610	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 789,665	\$ 789,665	46
47	TOTAL EQUITY (page 18, line 24)	\$ (488,857)	\$ (306,854)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 300,808	\$ 482,811	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (208,455)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (208,455)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(280,402)	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)	\$ (280,402)	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)	\$ (488,857)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 504,321	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 504,321	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	34	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34	23
D. Non-Operating Revenue			
24	Contributions	2,306	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,306	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	4,204	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,204	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 510,865	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	77,411	31
32	Health Care	219,623	32
33	General Administration	408,224	33
B. Capital Expense			
34	Ownership	48,407	34
C. Ancillary Expense			
35	Special Cost Centers	3,247	35
36	Provider Participation Fee	34,355	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 791,267	40
41	Income before Income Taxes (line 30 minus line 40)**	(280,402)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (280,402)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 504,321	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)	\$ 504,321	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Sch 19A If not, please attach a reconciliation.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Park Place
0040360
6/30/2016

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	452	10,801	22.46	3
4	Licensed Practical Nurses	734	12,172	14.10	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	1,770	16,793	8.91	15
16	Dishwashers				16
17	Maintenance Workers	854	8,462	8.75	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	260	8,921	31.19	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	67	2,742	38.62	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	119	2,411	15.86	28
29	Resident Services Coordinator	2,369	34,669	13.57	29
30	Habilitation Aides (DD Homes)	14,901	141,160	8.97	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	21,526	238,131 *	10.35	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	22	\$ 1,199	L1, C3 35
36	Medical Director	Monthly	4,800	L9, C3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	811	L10, C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			L10a, C3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			L10a, C3 43
44	Activity Consultant			44
45	Social Service Consultant	27	1,461	L12, C3 45
46	Other(specify) <u>Dental</u>	17	832	L10, C3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	66	\$ 9,103	49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina Durbin	Administrator	0	\$ 8,921	Workers' Compensation Insurance	\$ 23,774	IDPH License Fee	\$	
				Unemployment Compensation Insurance	9,606	Advertising: Employee Recruitment		
				FICA Taxes	17,537	Health Care Worker Background Check		
				Employee Health Insurance	15,166	(Indicate # of checks performed)		
				Employee Meals	4,473	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	452	
				Life Insurance	234	Miscellaneous Dues & Fees	313	
				Other Employee Benefits	237			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 8,921					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Allocated from Progressive Housing, Inc.			\$ 295,125	N/A			Out-of-State Travel	\$
							In-State Travel	410
							Seminar Expense	159
							Allocated from Home Office	1,489
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 295,125				Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
Paychex	Payroll Service		\$ 3,059					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,059					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

