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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0040360

Facility Name: Park Place

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

County: Washington

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
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 7/1/16 to 6/30/17 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) Lawrence A. Manson
(Title) Chief Executive 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' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	4,348			4,348	13
14	TOTALS	4,348			4,348	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.45%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 [X] Date 04/30/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ 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: 6/30/2017 Fiscal Year: 6/30/2017

* 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: 7/1/16 Ending: 6/30/17

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	15,339	1,696	1,347	18,382		18,382		18,382			1
2	Food Purchase		21,775		21,775		21,775		21,775			2
3	Housekeeping		2,014		2,014		2,014	50	2,064			3
4	Laundry		1,622		1,622		1,622		1,622			4
5	Heat and Other Utilities			16,959	16,959		16,959		16,959			5
6	Maintenance	9,681	1,551	4,173	15,405		15,405	1,098	16,503			6
7	Other (specify):*											7
8	TOTAL General Services	25,020	28,658	22,479	76,157		76,157	1,148	77,305			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	215,219	4,822	2,117	222,158		222,158		222,158			10
10a	Therapy											10a
11	Activities		1,024	62	1,086		1,086		1,086			11
12	Social Services			1,667	1,667		1,667		1,667			12
13	CNA Training											13
14	Program Transportation			3,968	3,968		3,968		3,968			14
15	Other (specify):*			268	268		268		268			15
16	TOTAL Health Care and Programs	215,219	5,846	12,882	233,947		233,947		233,947			16
	C. General Administration											
17	Administrative	9,473		138,255	147,728		147,728	(138,255)	9,473			17
18	Directors Fees							4,284	4,284			18
19	Professional Services			4,268	4,268		4,268	6,687	10,955			19
20	Dues, Fees, Subscriptions & Promotions			859	859		859	1,716	2,575			20
21	Clerical & General Office Expenses	3,906	2,105	14,806	20,817		20,817	66,019	86,836			21
22	Employee Benefits & Payroll Taxes			74,243	74,243		74,243	11,027	85,270			22
23	Inservice Training & Education			1,187	1,187		1,187		1,187			23
24	Travel and Seminar			193	193		193	1,477	1,670			24
25	Other Admin. Staff Transportation			2,106	2,106		2,106	1,075	3,181			25
26	Insurance-Prop.Liab.Malpractice			8,847	8,847		8,847	563	9,410			26
27	Other (specify):*											27
28	TOTAL General Administration	13,379	2,105	244,764	260,248		260,248	(45,407)	214,841			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	253,618	36,609	280,125	570,352		570,352	(44,259)	526,093			29

*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

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: 7/1/16 Ending: 6/30/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,965	3,965		3,965	11,958	15,923			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,655	29,655		29,655	13,268	42,923			32
33	Real Estate Taxes			1,288	1,288		1,288	(1,288)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,588	2,588			35
36	Other (specify):*											36
37	**TOTAL Ownership**			34,908	34,908		34,908	26,526	61,434			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,176		3,176		3,176		3,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,260	30,260		30,260		30,260			42
43	Other (specify):* **Disallowed Costs**											43
44	**TOTAL Special Cost Centers**		3,176	30,260	33,436		33,436		33,436			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	253,618	39,785	345,293	638,696		638,696	(17,733)	620,963			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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	10,266	30		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				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	(27,999)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (17,733)		$	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 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))**	$ (17,733)		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

BHF USE ONLY									
48		49		50		51		52	

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS **Page 5A**

Park Place

ID# **0040360**

Report Period Beginning: **7/1/16**

Ending: **6/30/17**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO Costs	$ (27,791)	43	1
2	Non-Care Real Estate Taxes	(1,288)	33	2
3	Expense Building Improvements under $2,500	1,080	6	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**	(27,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	50	0	0	0	0	0	0	0	0	0	50	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,080	18	0	0	0	0	0	0	0	0	0	1,098	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,080	68	0	0	0	0	0	0	0	0	0	1,148	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	0	(138,255)	0	0	0	0	0	0	0	0	(138,255)	17
18	Directors Fees	0	4,284	0	0	0	0	0	0	0	0	0	4,284	18
19	Professional Services	0	6,687	0	0	0	0	0	0	0	0	0	6,687	19
20	Fees, Subscriptions & Promotions	0	1,716	0	0	0	0	0	0	0	0	0	1,716	20
21	Clerical & General Office Expenses	0	66,019	0	0	0	0	0	0	0	0	0	66,019	21
22	Employee Benefits & Payroll Taxes	0	11,027	0	0	0	0	0	0	0	0	0	11,027	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,477	0	0	0	0	0	0	0	0	0	1,477	24
25	Other Admin. Staff Transportation	0	1,075	0	0	0	0	0	0	0	0	0	1,075	25
26	Insurance-Prop.Liab.Malpractice	0	563	0	0	0	0	0	0	0	0	0	563	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	92,848	(138,255)	0	0	0	0	0	0	0	0	(45,407)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,080	92,916	(138,255)	0	0	0	0	0	0	0	0	(44,259)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Park Place** **#** **0040360** **Report Period Beginning:** **7/1/16** **Ending:** **6/30/17**

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	**10,266**	**1,692**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11,958**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**13,268**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,268**	**32**
33	Real Estate Taxes	**(1,288)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,288)**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**2,588**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,588**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**8,978**	**17,548**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**26,526**	**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):*	**(27,791)**	**0**	**27,791**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**(27,791)**	**0**	**27,791**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(17,733)**	**110,464**	**(110,464)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(17,733)**	**45**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Progressive Housing, Inc.	100.00%	$ 50	$ 50	1
2	V	6	Maintenance		Progressive Housing, Inc.	100.00%	18	18	2
3	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,284	4,284	3
4	V	19	Professional Services		Progressive Housing, Inc.	100.00%	6,687	6,687	4
5	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,716	1,716	5
6	V	21	Clerical and General Office	36	Progressive Housing, Inc.	100.00%	66,055	66,019	6
7	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	11,027	11,027	7
8	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,477	1,477	8
9	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	1,075	1,075	9
10	V	26	Insurance		Progressive Housing, Inc.	100.00%	563	563	10
11	V	30	Depreciation		Progressive Housing, Inc.	100.00%	1,692	1,692	11
12	V	32	Interest	126	Progressive Housing, Inc.	100.00%	13,394	13,268	12
13	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,588	2,588	13
14	Total			$ 162			$ 110,626	$ * 110,464	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	$ 27,791	$ 27,791	15
16	V	17	Administrative	138,255	Progressive Housing, Inc.	100.00%		(138,255)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,255			$ 27,791	$ * (110,464)	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 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 -closed	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Aviston Terrace	Aviston	& Housing	Waltonville	Workshop	6
7			Terra Estates-closed	Hoyleton	Progressive Careers			7
8			Joshua Manor	Hoyleton	& 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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Edward Childers	Chairman	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	$ 564	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,948		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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	3	Housekeeping	Bed Capacity/Specific Alloc.	263	29	968		16	$ 50	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	263	29	303		16	18	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	263	29	72,251		16	4,284	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	263	29	117,723		16	6,687	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	263	29	29,301		16	1,716	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	263	29	1,117,820	949,691	16	66,055	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	263	29	186,014		16	11,027	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	263	29	24,967		16	1,477	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	263	29	18,123		16	1,075	9
10	26	Insurance	Bed Capacity/Specific Alloc.	263	29	9,561		16	563	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	263	29	28,653		16	1,692	11
12	32	Interest	Bed Capacity/Specific Alloc.	263	29	214,829		16	13,394	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	263	29	43,864		16	2,588	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	263	29	218,508		16	27,791	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,082,885	$ 949,691		$ 138,417	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 28,472	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 766,870	$ 648,325			$ 28,472	9
	B. Non-Facility Related*											
10								Amortization			1,183	10
11								Home Office Allocation			13,394	11
12								Interest Income Offset-HO			(126)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,451	14
15	TOTALS (line 9+line14)						$ 766,870	$ 648,325			$ 42,923	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' PREPARATION 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:** 7/1/16 **Ending:** 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	**2016**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 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:			
	2012		**8**
	2013		**9**
	2014		**10**
	2015		**11**
	2016		**12**

N/A - Not for profit entity

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	**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' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Washington

FACILITY IDPH LICENSE NUMBER 0040360

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 7/1/16 Ending: 6/30/17

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			6,834	2
3	TOTALS	13,916		$ 26,834	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 *	$	40	$ 10,150	$ 10,150	$ 245,233	4
5				2013	(15,586)		40	(390)	(390)	(9,068)	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		15	15	15	548	12
13	Water Services Repairs			2004	1,071		15	71	71	934	13
14	Kitchen Coutner Tops			2005	625		15	42	42	510	14
15	Kitchen Cabinets			2005	3,445		15	230	230	2,858	15
16	Kitchen Remodel			2005	1,429		15	95	95	1,160	16
17	Air Conditioning Repair			2005	1,650		15	110	110	1,302	17
18	Bathroom Remodel-disposed			2006			15				18
19	Bedroom Remodel-disposed			2007			15				19
20	Gazebo			2007	1,896		15	126	126	1,209	20
21	Alarm Repairs			2008	1,875		15	125	125	1,136	21
22	Heating/ Cooling			2009	1,928		15	129	129	1,050	22
23	Building Improvements			2009	806		15	54	54	436	23
24	Repair to Water Main			2009	2,083		15	139	139	1,086	24
25	Damper			2013	597		10	60	60	245	25
26	Air Conditioner			2014	2,410		15	161	161	496	26
27	Replace Roof (Gross of Write off of Old Roof-See Line 5)			2014	22,283		25	891	891	2,896	27
28	Remodel 2 Bathrooms - repair and replace walls and door frames			2014	9,311		15	621	621	1,631	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		15	53	53	115	31
32											32
33											33
34	Financial Statement Depreciation					3,965			(3,965)		34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	Allocation from Home Office		11,751			320	320		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)		$ 462,267	$ 3,965		$ 13,002	$ 9,037	$ 261,127	70

SEE ACCOUNTANTS' PREPARATION 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: 7/1/16 Ending: 6/30/17

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	$ 12,930	$	1,468	$ 1,468	5-10 Yrs	$ 5,123	71
72	Current Year Purchases	1,821		81	81	10 Yrs	81	72
73	Fully Depreciated Assets	17,411				5-10 Yrs	17,411	73
74	Allocated from Home Office	22,205		1,222	1,222		18,863	74
75	TOTALS	$ 54,367	$	$ 2,771	$ 2,771		$ 41,478	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			851		150	150			79
80	TOTALS			$ 29,301	$	$ 150	$ 150		$ 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)	$ 572,769	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,965	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,923	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,958	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 331,055	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.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 2,588 Description: Allocated from Home Office - postage machine $92, copier $1,701, storage $795
    (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	N/A		$	$	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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

   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' PREPARATION REPORT

Facility Name & ID Number Park Place

STATE OF ILLINOIS
0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				3,176		3,176	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			$		$	$ 3,176		$ 3,176	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

STATE OF ILLINOIS

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/17 (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	$ 41,139	$ 41,139	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,806)	93,756	93,756	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,984	5,984	7
8	Accounts Receivable (owners or related parties)	(94,072)	(94,072)	8
9	Other(specify): Reserves/Deposits	80,250	80,250	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 127,057	$ 127,057	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,834	13
14	Buildings, at Historical Cost	40,580	462,267	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	35,427	83,668	16
17	Accumulated Depreciation (book methods)	(25,031)	(331,055)	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	4,223	4,223	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 75,199	$ 245,937	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 202,256	$ 372,994	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,341	$ 13,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,255	25,255	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,375	1,375	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	51,579	51,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	30,689	30,689	36
37	Deferred Income	459	459	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 122,698	$ 122,698	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	Due to Bond Fund	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)**	$ 836,308	$ 836,308	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (634,052)	$ (463,314)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 202,256	$ 372,994	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (488,857)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (488,857)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(145,195)	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)**	$ (145,195)	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)**	$ (634,052)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 484,877	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 484,877	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	4,870	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,870	23
	D. Non-Operating Revenue		
24	Contributions	1,764	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,764	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	1,990	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,990	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 493,501	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	76,157	31
32	Health Care	233,947	32
33	General Administration	260,248	33
	B. Capital Expense		
34	Ownership	34,908	34
	C. Ancillary Expense		
35	Special Cost Centers	3,176	35
36	Provider Participation Fee	30,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 638,696	40
41	**Income before Income Taxes (line 30 minus line 40)****	(145,195)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (145,195)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 484,877	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)	$ 484,877	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 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
6/30/17

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: 7/1/16 Ending: 6/30/17

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	510	534	12,107	22.67	3
4	Licensed Practical Nurses	766	827	11,604	14.03	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	1,448	1,560	15,339	9.83	15
16	Dishwashers					16
17	Maintenance Workers	857	992	9,681	9.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	228	258	9,473	36.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	115	130	3,906	30.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	284	315	5,669	18.00	28
29	Resident Services Coordinator	1,880	2,069	30,053	14.53	29
30	Habilitation Aides (DD Homes)	14,610	15,296	155,786	10.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,698	21,981	$ 253,618 *	$ 11.54	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,347	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	1,099	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	1	62	L11, C3	44
45	Social Service Consultant	30	1,667	L12, C3	45
46	Other(specify) Dental	Monthly	893	L10, C3	46
47	Psychologist	Monthly	125	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	56	$ 9,993		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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 9,473
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 9,473

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 138,255
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 138,255

C. Professional Services

Vendor/Payee	Type	Amount
Paychex	Payroll Service	$ 1,891
Paycor	Payroll Service	1,762
Benetrac	Payroll Service	275
MyStaffingPro	Payroll Service	107
Sheakley Paysystems	Payroll Service	233
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 4,268

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,885
Unemployment Compensation Insurance	7,484
FICA Taxes	18,958
Employee Health Insurance	23,003
Employee Meals	4,241
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	258
Other Employee Benefits	414
Allocated from Home Office	11,027
TOTAL (agree to Schedule V, line 22, col.8)	$ 85,270

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)	
Patient Background Checks	
Hiring Expense	417
Miscellaneous Dues & Fees	442
Allocated from Home Office	1,716
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,575

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	70
Seminar Expense	123
Allocated from Home Office	1,477
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,670

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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. $ **1,255** 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. $ **30,260**
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' PREPARATION 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. $ **4,241** 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? **56%**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) 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