		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0040360

Facility Name: Park Place

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

County: Christian

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

HFS ID Number:

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

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 C (3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2019 to 6/30/2020 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: 7/1/2019 Ending: 6/30/2020

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	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,061			5,061	13
14	TOTALS	5,061			5,061	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.42%

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: 6/30/2020 Fiscal Year: 6/30/2020

* 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: 7/1/2019 Ending: 6/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	16,059	1,973	1,144	19,176		19,176		19,176			1
2	Food Purchase		32,548		32,548		32,548		32,548			2
3	Housekeeping		2,537		2,537		2,537	13	2,550			3
4	Laundry		1,442		1,442		1,442		1,442			4
5	Heat and Other Utilities			16,199	16,199		16,199		16,199			5
6	Maintenance	12,980	6,077	7,215	26,272		26,272	206	26,478			6
7	Other (specify):*											7
8	**TOTAL General Services**	29,039	44,577	24,558	98,174		98,174	219	98,393			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	223,680	6,623	1,166	231,469		231,469		231,469			10
10a	Therapy											10a
11	Activities		5,038	13	5,051		5,051		5,051			11
12	Social Services			1,398	1,398		1,398		1,398			12
13	CNA Training											13
14	Program Transportation			5,974	5,974		5,974		5,974			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	223,680	11,661	12,151	247,492		247,492		247,492			16
	C. General Administration											
17	Administrative	16,390		108,557	124,947		124,947	(108,557)	16,390			17
18	Directors Fees							4,375	4,375			18
19	Professional Services			8,506	8,506		8,506	6,892	15,398			19
20	Dues, Fees, Subscriptions & Promotions			1,465	1,465		1,465	2,644	4,109			20
21	Clerical & General Office Expenses	8,572	4,177	13,030	25,779		25,779	71,990	97,769			21
22	Employee Benefits & Payroll Taxes			71,991	71,991		71,991	11,403	83,394			22
23	Inservice Training & Education			2,063	2,063		2,063		2,063			23
24	Travel and Seminar			765	765		765	2,068	2,833			24
25	Other Admin. Staff Transportation			2,579	2,579		2,579	1,150	3,729			25
26	Insurance-Prop.Liab.Malpractice			9,712	9,712		9,712	464	10,176			26
27	Other (specify):*											27
28	**TOTAL General Administration**	24,962	4,177	218,668	247,807		247,807	(7,571)	240,236			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	277,681	60,415	255,377	593,473		593,473	(7,352)	586,121			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: 7/1/2019 Ending: 6/30/2020

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			9,937	9,937		9,937	16,764	26,701			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,306	1,306		1,306	(965)	341			32
33	Real Estate Taxes			6,601	6,601		6,601	(6,601)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,212	2,212			35
36	Other (specify):*											36
37	**TOTAL Ownership**			17,844	17,844		17,844	11,410	29,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,992		1,992		1,992		1,992			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,291	37,291		37,291		37,291			42
43	Other (specify):* Disallowed Costs			315	315		315	(315)				43
44	**TOTAL Special Cost Centers**		1,992	37,606	39,598		39,598	(315)	39,283			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	277,681	62,407	310,827	650,915		650,915	3,743	654,658			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: 7/1/2019 Ending: 6/30/2020

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	14,500	30		9
10	Interest and Other Investment Income	(965)	32		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	(29)	20		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	(28)	19		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	(9,735)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,743		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,743		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Park Place

ID# 0040360

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO Costs	$ (1,873)	43	1
2	Disallow Nonallowable Real Estate Taxes	(6,601)	33	2
3	Miscellaneous Income Offset	(5)	21	3
4	Rental Income Offset	(941)	34	4
5	Disallow Day Program Exp	(315)	43	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**	(9,735)		49

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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%	$ 13	$ 13	1
2	V	6	Maintenance		Progressive Housing, Inc.	100.00%	206	206	2
3	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,375	4,375	3
4	V	19	Professional Services		Progressive Housing, Inc.	100.00%	6,920	6,920	4
5	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,673	2,673	5
6	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	71,995	71,995	6
7	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	11,403	11,403	7
8	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	2,068	2,068	8
9	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	1,150	1,150	9
10	V	26	Insurance		Progressive Housing, Inc.	100.00%	464	464	10
11	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,264	2,264	11
12	V	34	Rent		Progressive Housing, Inc.	100.00%	941	941	12
13	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,212	2,212	13
14	Total			$			$ 106,684	$ * 106,684	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: 7/1/2019 Ending: 6/30/2020

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%	$ 1,873	$ 1,873	15
16	V	17	Administrative	108,557	Progressive Housing, Inc.	100.00%		(108,557)	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			$ 108,557			$ 1,873	$ * (106,684)	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: 7/1/2019 Ending: 6/30/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	8,230	3Hrs/MTG	1.00	Dir. Fees	$ 570	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,229	3Hrs/MTG	1.00	Dir. Fees	571	L18,C8	3
4	Hal Brown	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	6
7	Eileen Mullin	Director	Board Member	None	8,978	3Hrs/MTG	1.00	Dir. Fees	622	L18,C8	7
8	Julie Lilie	Director-Partial yr	Board Member	None	4,489	3Hrs/MTG	1.00	Dir. Fees	311	L18,C8	8
9	Shawn Jeffers	Director-Partial yr	Board Member	None	1,496	3Hrs/MTG	1.00	Dir. Fees	104	L18,C8	9
10											10
11					Misc Expenses				20		11
12											12
13								TOTAL	$ 4,375		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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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.	252	28	$ 523	$	16	$ 13	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	252	28	4,326		16	206	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	252	28	67,510		16	4,375	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	252	28	109,179		16	6,920	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	252	28	42,077		16	2,673	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	252	28	1,118,951	935,187	16	71,995	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	252	28	195,610		16	11,403	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	252	28	33,408		16	2,068	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	252	28	18,416		16	1,150	9
10	26	Insurance	Bed Capacity/Specific Alloc.	252	28	7,288		16	464	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	252	28	34,937		16	2,264	11
12	34	Rent	Bed Capacity/Specific Alloc.	252	28	14,823		16	941	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	252	28	45,991		16	2,212	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	252	28	43,564		16	1,873	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,736,603	$ 935,187		$ 108,557	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Enterprise		X	Vehicle	$605.11	2/2019	29,210	21,772	1/2024	0.0588	1,306	6
7	Peoples Bank		X	PPP Loan		4/14/20	116,788	116,788				7
8												8
9	TOTAL Facility Related				$605.11		$ 145,998	$ 138,560			$ 1,306	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(965)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (965)	14
15	TOTALS (line 9+line14)						$ 145,998	$ 138,560			$ 341	15

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

* 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: 7/1/2019 Ending: 6/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2020 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:		
2015	N/A	8
2016	N/A	9
2017	N/A	10
2018	N/A	11
2019	N/A	12

N/A - Not for profit entity

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Place COUNTY Christian

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 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 7/1/2019 Ending: 6/30/2020

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			7,369	2
3	TOTALS	13,916		$ 27,369	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$ 275,683	4
5				2013	(15,586)		40	(390)	(390)	(10,238)	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			548	12
13	Water Services Repairs			2004	1,071		15			1,071	13
14	Kitchen Coutner Tops			2005	625		15	31	31	625	14
15	Kitchen Cabinets			2005	3,445		15	127	127	3,445	15
16	Kitchen Remodel			2005	1,429		15	79	79	1,429	16
17	Air Conditioning Repair			2005	1,650		15	110	110	1,632	17
18	Bathroom Remodel-disposed			2006			15				18
19	Bedroom Remodel-disposed			2007			15				19
20	Gazebo			2007	1,896		15	126	126	1,587	20
21	Alarm Repairs			2008	1,875		15	125	125	1,511	21
22	Heating/ Cooling			2009	1,928		15	129	129	1,437	22
23	Building Improvements			2009	806		15	54	54	598	23
24	Repair to Water Main			2009	2,083		15	139	139	1,503	24
25	Damper			2013	597		10	60	60	425	25
26	Air Conditioner			2014	2,410		15	161	161	979	26
27	Replace Roof (Gross of Write off of Old Roof-See Line 5)			2014	22,283		25	891	891	5,569	27
28	Remodel 2 Bathrooms - repair and replace walls and door frames,			2014	9,311		15	621	621	3,494	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	274	31
32	Women's Bath-New Shower Floor/Tile Surround/Plumbing/Fixtures			2018	3,450		15	230	230	460	32
33	Replace Kitchen Cabinets and Countertops			2019	14,959		10	1,496	1,496	1,730	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	Financial Statement Depreciation			9,937			(9,937)		47
48									48
49									49
50									50
51	Allocated from Home Office		14,698			2,264	2,264	26,747	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)		$ 483,623	$ 9,937		$ 16,456	$ 6,519	$ 327,859	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: 7/1/2019 Ending: 6/30/2020

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	$ 16,743	$	$ 1,550	$ 1,550	5-10 Yrs	$ 10,796	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	16,467				5-10 Yrs	16,467	73
74	Allocated from Home Office	26,514						74
75	TOTALS	$ 59,724	$	$ 1,550	$ 1,550		$ 27,263	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 Repairs	2008	992				5	992	77
78	Resident Transportation	2019 Dodge Grand Caravan	2019	43,475		8,695	8,695	5	13,051	78
79	Allocated from Home Office			2,944						79
80	TOTALS			$ 74,869	$	$ 8,695	$ 8,695		$ 41,501	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)	$ 645,585	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,937	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,701	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,764	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 396,623	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 2,212 Description: Allocated from Home Office - Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

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				1,992		1,992	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			$		$	$ 1,992		$ 1,992	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: 7/1/2019 Ending: 6/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2020 (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	$ 262,071	$ 262,071	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,073)	133,716	133,716	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(3,321)	(3,321)	6
7	Other Prepaid Expenses	14,857	14,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves/Deposits	1,566	1,566	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 408,889	$ 408,889	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,369	13
14	Buildings, at Historical Cost	18,409	483,623	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	84,814	134,593	16
17	Accumulated Depreciation (book methods)	(46,686)	(396,623)	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 (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 76,537	$ 248,962	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 485,426	$ 657,851	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 52,370	$ 52,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	116,788	116,788	29
30	Accrued Salaries Payable	38,511	38,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,195	2,195	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Advances from DHS	18,822	18,822	36
37	Intercompany Payable	270,598	270,598	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 499,284	$ 499,284	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,772	21,772	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 21,772	$ 21,772	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 521,056	$ 521,056	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (35,630)	$ 136,795	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 485,426	$ 657,851	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (113,966)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (113,966)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	78,336	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)**	$ 78,336	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)**	$ (35,630)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$ 723,135	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 723,135	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	(298)	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (298)	23
	D. Non-Operating Revenue		
24	Contributions	1,613	24
25	Interest and Other Investment Income***	965	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,578	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Allocated from Home Office-See Pg 19B	3,836	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,836	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 729,251	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	98,174	31
32	Health Care	247,492	32
33	General Administration	247,807	33
	B. Capital Expense		
34	Ownership	17,844	34
	C. Ancillary Expense		
35	Special Cost Centers	2,307	35
36	Provider Participation Fee	37,291	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 650,915	40
41	**Income before Income Taxes (line 30 minus line 40)****	78,336	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 78,336	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 723,135	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)	$ 723,135	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

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.

Park Place
0040360
6/30/2020

SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Gain/Loss on Sale of Assets	(21)
Miscellaneous Income	5
Rental Income	3,852
Total Line 28a	**3,836**

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	992	1,062	24,245	22.83	3
4	Licensed Practical Nurses					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	1,346	1,408	16,059	11.41	15
16	Dishwashers					16
17	Maintenance Workers	673	1,024	12,980	12.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	287	388	16,390	42.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	297	316	8,572	27.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,176	2,268	41,801	18.43	29
30	Habilitation Aides (DD Homes)	12,630	13,433	157,634	11.73	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,401	19,899	$ 277,681 *	$ 13.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	20	$ 1,144	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	335	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	13	L11, C3	44
45	Social Service Consultant	23	1,398	L12, C3	45
46	Other(specify) Dental	Monthly	831	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	$ 7,321		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 14,667
Shallon Spinner	Administrator	0	1,723
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 16,390

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 108,557
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 108,557

C. Professional Services

Vendor/Payee	Type	Amount
Paycor	Payroll Service	$ 4,258
Janet Scellato	Accounting Consultant	3,783
Wipfli	Accounting Services	437
Hinshaw and Culbuertson, LLP	Legal Services	28
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 8,506

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,722
Unemployment Compensation Insurance	2,885
FICA Taxes	20,568
Employee Health Insurance	18,413
Employee Meals	5,339
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	221
Other Employee Benefits	7,843
Allocated from Home Office	11,403
TOTAL (agree to Schedule V, line 22, col.8)	$ 83,394

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

Description	Line #	Amount
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	829
Miscellaneous Dues & Fees	636
Allocated from Home Office	2,673
Less: Public Relations Expense	(29)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,109

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	443
Seminar Expense	322
Allocated from Home Office	2,068
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,833

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,458** 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. $ **37,291**
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. $ **5,339** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **100% Line 14**
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 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.