

		FOR BHF USE					

LL1

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0040360</u></p> <p>Facility Name: <u>Park Place</u></p> <p>Address: <u>205 Park Avenue</u> <u>Pana</u> <u>62557</u> Number City Zip Code</p> <p>County: <u>Christian</u></p> <p>Telephone Number: <u>(217) 562-7023</u> Fax # <u>(217) 562-5516</u></p> <p>HFS ID Number: <u>371238076004</u></p> <p>Date of Initial License for Current Owners: <u>05/01/1993</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jerry Johnson</u> Telephone Number: <u>(309) 685-0595 ext 302</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2008</u> to <u>06/30/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Ronald Schroeder</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CEO</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Rob Keime</u> <u>Accountant</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Rob Keime</u> <u>3325 W. Wilshire Dr. Peoria, IL</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(309) 691-1403</u> Fax # ()</td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Ronald Schroeder</u> (Date) _____		(Title) <u>CEO</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Rob Keime</u> <u>Accountant</u>	(Firm Name & Address) <u>Rob Keime</u> <u>3325 W. Wilshire Dr. Peoria, IL</u>		(Telephone) <u>(309) 691-1403</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																			
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																			
IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																			
	<input type="checkbox"/> "Sub-S" Corp.																																				
	<input type="checkbox"/> Limited Liability Co.																																				
	<input type="checkbox"/> Trust																																				
	<input type="checkbox"/> Other _____																																				
Officer or Administrator of Provider	(Signed) _____																																				
	(Type or Print Name) <u>Ronald Schroeder</u> (Date) _____																																				
	(Title) <u>CEO</u>																																				
Paid Preparer	(Signed) _____																																				
	(Date) _____																																				
	(Print Name and Title) <u>Rob Keime</u> <u>Accountant</u>																																				
	(Firm Name & Address) <u>Rob Keime</u> <u>3325 W. Wilshire Dr. Peoria, IL</u>																																				
	(Telephone) <u>(309) 691-1403</u> Fax # ()																																				

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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 16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>4,420</u>	<u>0</u>		<u>4,420</u>	13
14	TOTALS	<u>4,420</u>			<u>4,420</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.68%

D. How many bed-hold days during this year were paid by the Department? 305 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/30/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 0 and days of care provided n/a

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Park Place

#0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			19,014	19,014		19,014	2,367	21,381		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			35,030	35,030		35,030	(7,195)	27,835		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds							1,516	1,516		34
35	Rent-Equipment & Vehicles							101	101		35
36	Other (specify):*										36
37	TOTAL Ownership			54,044	54,044		54,044	(3,211)	50,833		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			31,376	31,376		31,376		31,376		42
43	Other (specify):*			144,314	144,314		144,314	(144,314)			43
44	TOTAL Special Cost Centers			175,690	175,690		175,690	(144,314)	31,376		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	175,273	37,286	329,988	542,547		542,547	(82,964)	459,583		45

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

Park Place

ID# 0040360

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Place# 0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	88	63	21	61	22	255	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	363	317	141	224	83	1,128	5
6	Maintenance	0	0	0	0	0	0	108	83	34	194	46	465	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	559	463	196	479	151	1,848	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	(581)	0	0	0	0	0	(492)	229	0	26	35	(783)	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 Program	(581)	0	0	0	0	0	(492)	229	0	26	35	(783)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	17,154	12,377	4,100	11,017	1,404	46,052	17
18	Directors Fees	0	0	(2)	0	0	(4)	0	0	0	0	0	(6)	18
19	Professional Services	0	0	0	0	0	(14)	0	0	0	0	0	(14)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	18	58	54	86	33	249	20
21	Clerical & General Office Expenses	0	1	1	0	0	(5)	385	339	76	333	65	1,195	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	2,267	2,473	729	2,164	3,575	11,208	22
23	Inservice Training & Education	0	0	0	0	0	(1)	1,143	686	315	761	276	3,180	23
24	Travel and Seminar	0	0	0	0	0	0	158	22	0	38	0	218	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	381	276	90	266	401	1,414	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	1	(1)	0	0	(24)	21,506	16,231	5,364	14,665	5,754	63,496	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(581)	1	(1)	0	0	(24)	21,573	16,923	5,560	15,170	5,940	64,561	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Place# 0040360 Report Period Beginning:07/01/2008 Ending: 06/30/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	740	601	204	613	209	2,367	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,358)	0	0	0	0	123	89	67	39	61	(216)	(7,195)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	516	380	124	367	129	1,516	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	22	20	20	20	19	101	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,358)	0	0	0	0	123	1,367	1,068	387	1,061	141	(3,211)	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):*	(145,888)	0	0	0	0	0	565	288	110	481	130	(144,314)	43
44	TOTAL Special Cost Centers	(145,888)	0	0	0	0	0	565	288	110	481	130	(144,314)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(153,827)	1	(1)	0	0	99	23,505	18,279	6,057	16,712	6,211	(82,964)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		
SEE ATTACHED SCHEDULE 7A						

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		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)	
		Item							
1	V	18	BOARD FEES	\$ 817	PROGRESSIVE HOUSING, INC.	100.00%	\$ 817		1
2	V	19	PROFESSIONAL FEES	2,145	PROGRESSIVE HOUSING, INC.	100.00%	2,145		2
3	V	20	LICENSE, DUES	31	PROGRESSIVE HOUSING, INC.	100.00%	31		3
4	V	21	GENERAL OFFICE	649	PROGRESSIVE HOUSING, INC.	100.00%	650	1	4
5	V	23	INSERVICE TRAVEL	152	PROGRESSIVE HOUSING, INC.	100.00%	152		5
6	V	32	INTEREST	4	PROGRESSIVE HOUSING, INC.	100.00%	4		6
7	V	32	INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			7
8	V	22	EMPLOYEE BENEFITS	(27)	PROGRESSIVE HOUSING, INC.	100.00%	(27)		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,771			\$ 3,772	\$ *	1 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	18 BOARD FEES	\$ 607	PROGRESSIVE HOUSING, INC.	100.00%	\$ 605	\$	(2)	15
16	V	19 PROFESSIONAL FEES	1,722	PROGRESSIVE HOUSING, INC.	100.00%	1,722			16
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%				17
18	V	21 GENERAL OFFICE	741	PROGRESSIVE HOUSING, INC.	100.00%	742		1	18
19	V	23 INSERVICE TRAVEL	84	PROGRESSIVE HOUSING, INC.	100.00%	84			19
20	V	32 INTEREST	7	PROGRESSIVE HOUSING, INC.	100.00%	7			20
21	V	32 INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%				21
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%				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		\$ 3,161			\$ 3,160	\$ *	(1)	39

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

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

07/01/2008

Ending: 06/30/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	BOARD FEES	\$ 170	PROGRESSIVE HOUSING, INC.	100.00%	\$ 170	\$	15
16	V	19	PROFESSIONAL FEES	188	PROGRESSIVE HOUSING, INC.	100.00%	188		16
17	V	20	LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21	GENERAL OFFICE	161	PROGRESSIVE HOUSING, INC.	100.00%	161		18
19	V	23	INSERVICE TRAVEL	23	PROGRESSIVE HOUSING, INC.	100.00%	23		19
20	V	32	INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20
21	V	32	INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22	EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			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			\$ 542			\$ 542	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	BOARD FEES	\$ 665	PROGRESSIVE HOUSING, INC.	100.00%	\$ 665	\$	15
16	V	19	PROFESSIONAL FEES	622	PROGRESSIVE HOUSING, INC.	100.00%	622		16
17	V	20	LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21	GENERAL OFFICE	529	PROGRESSIVE HOUSING, INC.	100.00%	529		18
19	V	23	INSERVICE TRAVEL	90	PROGRESSIVE HOUSING, INC.	100.00%	90		19
20	V	32	INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20
21	V	32	INTEREST INCOME		PROGRESSIVE HOUSING, INC.	100.00%			21
22	V	22	EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			22
23	V	6	MAINTENCE	2	PROGRESSIVE HOUSING, INC.	100.00%	2		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			\$ 1,908			\$ 1,908	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	18 BOARD FEES	\$ 244	PROGRESSIVE HOUSING, INC.	100.00%	\$ 240	\$ (4)	15
16	V	19 PROFESSIONAL FEES	763	PROGRESSIVE HOUSING, INC.	100.00%	749	(14)	16
17	V	20 LICENSE, DUES		PROGRESSIVE HOUSING, INC.	100.00%			17
18	V	21 GENERAL OFFICE	261	PROGRESSIVE HOUSING, INC.	100.00%	256	(5)	18
19	V	23 INSERVICE TRAVEL	56	PROGRESSIVE HOUSING, INC.	100.00%	55	(1)	19
20	V	32 INTEREST		PROGRESSIVE HOUSING, INC.	100.00%			20
21	V	32 INTEREST INCOME	(6,591)	PROGRESSIVE HOUSING, INC.	100.00%	(6,468)	123	21
22	V	22 EMPLOYEE BENEFITS		PROGRESSIVE HOUSING, INC.	100.00%			22
23	V	6 MAINTENCE		PROGRESSIVE HOUSING, INC.	100.00%			23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ (5,267)			\$ (5,168)	\$ * 99	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 17,154	\$ 17,154	15
16	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18	18	17
18	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,267	2,267	18
19	V	23	INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,143	1,143	19
20	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	158	158	20
21	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	381	381	21
22	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	740	740	22
23	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	89	89	23
24	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	516	516	24
25	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22	22	25
26	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	363	363	26
27	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	108	108	27
28	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	565	565	28
29	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29
30	V	3	HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	88	88	30
31	V	21	OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	385	385	31
32	V	10	NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(492)	(492)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 23,505	\$ * 23,505	39

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

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17	ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 12,377	\$	12,377	15
16	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	58		58	17
18	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,473		2,473	18
19	V	23	INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	686		686	19
20	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22		22	20
21	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	276		276	21
22	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	601		601	22
23	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	67		67	23
24	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	380		380	24
25	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20		20	25
26	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	317		317	26
27	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	83		83	27
28	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	288		288	28
29	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				29
30	V	3	HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	63		63	30
31	V	21	OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	339		339	31
32	V	10	NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	229		229	32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 18,279	\$ *	18,279	39

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

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 4,100	\$ 4,100	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	54	54	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	729	729	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	315	315	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	90	90	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	204	204	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	21	21	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	124	124	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	141	141	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	34	34	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	110	110	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	18	18	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	21	21	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	76	76	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 6,057	\$ * 6,057	39

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

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 11,017	\$ 11,017	15
16	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			16
17	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	86	86	17
18	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,164	2,164	18
19	V	23	INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	761	761	19
20	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	38	38	20
21	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	266	266	21
22	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	613	613	22
23	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	61	61	23
24	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	367	367	24
25	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	20	20	25
26	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	224	224	26
27	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	194	194	27
28	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	481	481	28
29	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.			29
30	V	3	HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	61	61	30
31	V	21	OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	333	333	31
32	V	10	NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	26	26	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 16,712	\$ * 16,712	39

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

Facility Name & ID Number

Park Place

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17	ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	\$ 1,404	\$	1,404	15
16	V	19	PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				16
17	V	20	DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	33		33	17
18	V	22	EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	3,575		3,575	18
19	V	23	INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	276		276	19
20	V	24	TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.				20
21	V	26	INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	401		401	21
22	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	209		209	22
23	V	32	INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(106)		(106)	23
24	V	34	RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	129		129	24
25	V	35	EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	19		19	25
26	V	5	UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	83		83	26
27	V	6	MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	46		46	27
28	V	43	NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	130		130	28
29	V	32	MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(110)		(110)	29
30	V	3	HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	22		22	30
31	V	21	OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	65		65	31
32	V	10	NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	35		35	32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$			\$ 6,211	\$ *	6,211	39

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

Facility Name & ID Number

Park Place

#

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RONALD SCHROEDER	SECRETARY	BOARD MEMBER	NONE	8,709	3HRS/MTG	1.00	DIR. FEES	\$ 491	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBER	NONE	8,708	3HRS/MTG	1.00	DIR. FEES	492	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBER	NONE	8,708	3HRS/MTG	1.00	DIR. FEES	492	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBER	NONE	5,302	3HRS/MTG	1.00	DIR. FEES	298	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBER	NONE	4,546	3HRS/MTG	1.00	DIR. FEES	254	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBER	NONE	8,330	3HRS/MTG	1.00	DIR. FEES	470	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,497		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: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	BOARD FEES	NUMBER OF BEDS	290	23	\$ 14,800	\$ 16	\$ 817	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	290	23	38,879	16	2,145	2
3	20	LICENSE, DUES	NUMBER OF BEDS	290	23	559	16	31	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	290	23	11,795	16	650	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	290	23	2,758	16	152	5
6	32	INTEREST	NUMBER OF BEDS	290	23	69	16	4	6
7	32	INTEREST INCOME	NUMBER OF BEDS	290	23		16	0	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	290	23	(489)	16	(27)	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	TOTALS					\$ 68,371	\$	\$ 3,772	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	296	24	\$ 11,200	\$ 16	\$ 605	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	24	31,866	16	1,722	2
3	20	LICENSE, DUES	NUMBER OF BEDS	296	24		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	296	24	13,705	16	742	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	296	24	1,556	16	84	5
6	32	INTEREST	NUMBER OF BEDS	296	24	124	16	7	6
7	32	INTEREST INCOME	NUMBER OF BEDS	296	24		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	24		16		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	TOTALS					\$ 58,451	\$	\$ 3,160	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	302	25	\$ 3,200	\$ 16	\$ 170	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	25	3,552	16	188	2
3	20	LICENSE, DUES	NUMBER OF BEDS	302	25		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	302	25	3,050	16	162	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	302	25	427	16	23	5
6	32	INTEREST	NUMBER OF BEDS	302	25		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	302	25		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	25		16		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	TOTALS					\$ 10,229	\$	\$ 543	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	308	26	\$ 12,800	\$ 16	\$ 665	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	308	26	11,983	16	622	2
3	20	LICENSE, DUES	NUMBER OF BEDS	308	26		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	308	26	10,190	16	529	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	308	26	1,725	16	90	5
6	32	INTEREST	NUMBER OF BEDS	308	26		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	308	26		16		7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	308	26		16		8
9	6	MAINTENCE	NUMBER OF BEDS	308	26	35	16	2	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	TOTALS					\$ 36,733	\$	\$ 1,908	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	18	BOARD FEES	NUMBER OF BEDS	320	28	\$ 4,800	\$ 16	\$ 240	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	320	28	14,975	16	749	2
3	20	LICENSE, DUES	NUMBER OF BEDS	320	28		16		3
4	21	GENERAL OFFICE	NUMBER OF BEDS	320	28	5,123	16	256	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	320	28	1,100	16	55	5
6	32	INTEREST	NUMBER OF BEDS	320	28		16		6
7	32	INTEREST INCOME	NUMBER OF BEDS	320	28	(129,357)	16	(6,468)	7
8	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	320	28		16		8
9							16		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	TOTALS					\$	\$	\$ (5,168)	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	290	23	\$ 310,918	\$ 282,903	16	\$ 17,154	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	290	23			16		2
3	20	DUES, FEES	NUMBER OF BEDS	290	23	331		16	18	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	290	23	41,094		16	2,267	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	290	23	20,709		16	1,143	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	290	23	2,867		16	158	6
7	26	INSURANCE	NUMBER OF BEDS	290	23	6,907		16	381	7
8	30	DEPRECIATION	NUMBER OF BEDS	290	23	13,415		16	740	8
9	32	INTEREST	NUMBER OF BEDS	290	23	1,618		16	89	9
10	34	RENT	NUMBER OF BEDS	290	23	9,361		16	516	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	290	23	391		16	22	11
12	5	UTILITIES	NUMBER OF BEDS	290	23	6,577		16	363	12
13	6	MAINTENANCE	NUMBER OF BEDS	290	23	1,960		16	108	13
14	43	NONALLOWABLE	NUMBER OF BEDS	290	23	10,236		16	565	14
15	32	MISC INCOME	NUMBER OF BEDS	290	23			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	290	23	1,603		16	88	16
17	21	OFFICE	NUMBER OF BEDS	290	23	6,966		16	385	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	290	23	(8,924)		16	(492)	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 426,029	\$ 282,903		\$ 23,505	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	296	24	\$ 228,972	\$ 212,123	16	\$ 12,377	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	296	24			16		2
3	20	DUES, FEES	NUMBER OF BEDS	296	24	1,066		16	58	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	296	24	45,747		16	2,473	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	296	24	12,691		16	686	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	296	24	400		16	22	6
7	26	INSURANCE	NUMBER OF BEDS	296	24	5,114		16	276	7
8	30	DEPRECIATION	NUMBER OF BEDS	296	24	11,118		16	601	8
9	32	INTEREST	NUMBER OF BEDS	296	24	1,232		16	67	9
10	34	RENT	NUMBER OF BEDS	296	24	7,021		16	380	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	296	24	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	296	24	5,872		16	317	12
13	6	MAINTENANCE	NUMBER OF BEDS	296	24	1,534		16	83	13
14	43	NONALLOWABLE	NUMBER OF BEDS	296	24	5,332		16	288	14
15	32	MISC INCOME	NUMBER OF BEDS	296	24			16		15
16	3	HOUSEKEEPING	NUMBER OF BEDS	296	24	1,171		16	63	16
17	21	OFFICE	NUMBER OF BEDS	296	24	6,284		16	340	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	296	24	4,234		16	229	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 338,164	\$ 212,123		\$ 18,280	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	302	25	\$ 77,392	\$ 70,662	16	\$ 4,100	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	302	25			16		2
3	20	DUES, FEES	NUMBER OF BEDS	302	25	1,012		16	54	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	302	25	13,766		16	729	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	302	25	5,953		16	315	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	302	25			16		6
7	26	INSURANCE	NUMBER OF BEDS	302	25	1,705		16	90	7
8	30	DEPRECIATION	NUMBER OF BEDS	302	25	3,859		16	204	8
9	32	INTEREST	NUMBER OF BEDS	302	25	392		16	21	9
10	34	RENT	NUMBER OF BEDS	302	25	2,340		16	124	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	302	25	376		16	20	11
12	5	UTILITIES	NUMBER OF BEDS	302	25	2,656		16	141	12
13	6	MAINTENANCE	NUMBER OF BEDS	302	25	634		16	34	13
14	43	NONALLOWABLE	NUMBER OF BEDS	302	25	2,070		16	110	14
15	32	MISC INCOME	NUMBER OF BEDS	302	25	336		16	18	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	302	25	390		16	21	16
17	21	OFFICE	NUMBER OF BEDS	302	25	1,448		16	76	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	302	25			16		18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 114,329	\$ 70,662		\$ 6,057	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning: 07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE COST	308	26	\$ 212,076	\$ 190,326	16	\$ 11,017	1
2	19	PROFESSIONAL FEES	308	26			16		2
3	20	DUES, FEES	308	26	1,649		16	86	3
4	22	EMPLOYEE BENEFITS	308	26	41,666		16	2,164	4
5	23	INSERVICE EDUCATION	308	26	14,647		16	761	5
6	24	TRAVEL SEMINAR	308	26	741		16	38	6
7	26	INSURANCE	308	26	5,114		16	266	7
8	30	DEPRECIATION	308	26	11,804		16	613	8
9	32	INTEREST	308	26	1,168		16	61	9
10	34	RENT	308	26	7,071		16	367	10
11	35	EQUIPMENT RENTAL	308	26	376		16	20	11
12	5	UTILITIES	308	26	4,306		16	224	12
13	6	MAINTENANCE	308	26	3,743		16	194	13
14	43	NONALLOWABLE	308	26	9,257		16	481	14
15	32	MISC INCOME	308	26			16		15
16	3	HOUSEKEEPING	308	26	1,171		16	61	16
17	21	OFFICE	308	26	6,416		16	333	17
18	10	NURSING SUPPLIES	308	26	500		16	26	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 321,705	\$ 190,326		\$ 16,712	25

Facility Name & ID Number Park Place # 0040360 Report Period Beginning: 07/01/2008 Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMEN
 Street Address P.O. BOX 10528
 City / State / Zip Code PEORIA, IL. 61612
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	320	28	\$ 28,089	\$ 20,688	16	\$ 1,404	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	320	28			16		2
3	20	DUES, FEES	NUMBER OF BEDS	320	28	666		16	33	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	320	28	71,490		16	3,575	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	320	28	5,526		16	276	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	320	28			16		6
7	26	INSURANCE	NUMBER OF BEDS	320	28	8,024		16	401	7
8	30	DEPRECIATION	NUMBER OF BEDS	320	28	4,180		16	209	8
9	32	INTEREST	NUMBER OF BEDS	320	28	(2,115)		16	(106)	9
10	34	RENT	NUMBER OF BEDS	320	28	2,574		16	129	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	320	28	380		16	19	11
12	5	UTILITIES	NUMBER OF BEDS	320	28	1,669		16	83	12
13	6	MAINTENANCE	NUMBER OF BEDS	320	28	917		16	46	13
14	43	NONALLOWABLE	NUMBER OF BEDS	320	28	2,600		16	130	14
15	32	MISC INCOME	NUMBER OF BEDS	320	28	(2,200)		16	(110)	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	320	28	438		16	22	16
17	21	OFFICE	NUMBER OF BEDS	320	28	1,292		16	65	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	320	28	694		16	35	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 124,224	\$ 20,688		\$ 6,211	25

Facility Name & ID Number Park Place

0040360 Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,625 B. General Construction Type: Exterior Siding Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>13,916</u>	<u>1993</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	13,916		\$ 20,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Bed ^s *	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1993	1992	\$ 406,000	\$ 10,150	40	\$ 10,150	\$	\$ 164,091	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	BUILDING IMPROVEMENTS		1995	6,700	426	15	426		6,453	9
10	HEATING PIPING		1997	650	44	15	44		498	10
11	SHOWER		2000	2,266	151	15	151		1,284	11
12	FLOORING		2001	548	37	15	37		278	12
13	WATER SERVICE REPAIRS		2004	1,071	71	15	71		363	13
14	KITCHEN COUTNER TOPS		2005	625	41	15	41		181	14
15	KITCHEN CABINETS		2005	3,445	230	15	230		1,017	15
16	KITCHEN REMODEL		2005	1,429	95	15	95		397	16
17	AIR CONDITIONING REPAIR		2005	1,650	110	15	110		422	17
18	BATHROOM REMODEL		2006	710	47	15	47		122	18
19	BATHROOM REMODEL		2007	1,070	71	15	71		119	19
20	GAZEBO		2007	1,896	126	15	126		200	20
21	ALARM REPAIR		2008	1,875	125	15	125		135	21
22	HEATING / COOLING		2009	1,928	21	15	21		21	22
23	BUILDING IMPROVEMENTS		2009	806	4	15	4		4	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

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

See Page 12A, Line 70 for total

**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:

07/01/2008

Ending:

06/30/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 432,669	\$ 11,749		\$ 11,749	\$	\$ 175,585	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 12,320	\$ 1,425	\$ 1,425	\$	5-10YR	\$ 6,709	71
72	Current Year Purchases	1,506	78	78		5-10YR	78	72
73	Fully Depreciated Assets	7,983	72	72		5-10YR	7,983	73
74	ALLOCATED FROM PARENT		2,367	2,367				74
75	TOTALS	\$ 21,809	\$ 3,942	\$ 3,942	\$		\$ 14,770	75

D. Vehicle Depreciation (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 TRANS	2004 FORD	2004	\$ 27,458	\$ 5,492	\$ 5,492	\$		\$ 27,365	76
77	RESIDENT TRANS	2004 FORD	2008	992	198	198			231	77
78										78
79										79
80	TOTALS			\$ 28,450	\$ 5,690	\$ 5,690	\$		\$ 27,596	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)	\$ 502,928	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,381	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,381	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 217,951	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					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

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	<u>SCHEDULE 6E-I</u>				<u>1,516</u>			5
6								6
7	TOTAL				\$ 1,516			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 101

Description: POSTAGE MACHINE/CHAIR LIFT/SCH 6E-I

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u> </u>									12
13	Other (specify): <u> </u>									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 300	\$	1
2	Cash-Patient Deposits	11,064		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>17,136</u>)	158,306		3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108		6
7	Other Prepaid Expenses	(3,612)		7
8	Accounts Receivable (owners or related parties)	1,226,463		8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,392,629	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	406,000		14
15	Leasehold Improvements, at Historical Cost	26,669		15
16	Equipment, at Historical Cost	50,259		16
17	Accumulated Depreciation (book methods)	(217,951)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	75,596		21
22	Other Long-Term Assets (spe <u>Loan Costs</u>)	11,451		22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 372,024	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,764,653	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 53,284	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,064		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,433		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,453		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u> </u>			36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 88,234	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	494,699		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 494,699	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 582,933	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,181,720	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,764,653	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,038,604	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,038,604	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	138,116	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)	\$ 138,116	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)	\$ 1,176,720	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 538,302	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 538,302	3
B. Ancillary Revenue			
4	Day Care	134,657	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 134,657	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	581	24
25	Interest and Other Investment Income***	7,123	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,704	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 680,663	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	65,796	31
32	Health Care	181,888	32
33	General Administration	65,129	33
B. Capital Expense			
34	Ownership	54,044	34
C. Ancillary Expense			
35	Special Cost Centers	144,314	35
36	Provider Participation Fee	31,376	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 542,547	40
41	Income before Income Taxes (line 30 minus line 40)**	138,116	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 138,116	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.

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

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

Facility Name & ID Number Park Place

0040360

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	54	1,495	27.69	3
4	Licensed Practical Nurses	118	1,298	11.00	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	977	9,054	8.16	15
16	Dishwashers				16
17	Maintenance Workers	700	5,910	7.90	17
18	Housekeepers				18
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,440	21,572	13.03	29
30	Habilitation Aides (DD Homes)	15,487	135,944	8.22	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,776	\$ 175,273 *	\$ 8.67	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	22	\$ 1,752	L1,C3	35
36	Medical Director	monthly	4,800	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	14	608	L10,C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	22	1,723	L12,C3	45
46	Other(specify) <u>Psychological</u>	monthly	5,000	L15,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	\$ 13,883		49

C. CONTRACT NURSES

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

Facility Name & ID Number Park Place

0040360

Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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? yes
If YES, give association name and amount. IHCA \$868
- (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? 5-15yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,075 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. \$ 31,376
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,688 Has any meal income been offset against related costs? n/a 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? 96
d. Have vehicle usage logs been maintained? ADEQUATE RECORDS ARE 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.