

Facility Name & ID Number PARK PLACE CENTRALIA

0038646 Report Period Beginning: 7/01/2013 Ending: 6/30/2014

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	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	4,877			4,877	13
14	TOTALS	4,877			4,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.51%

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

6 (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 5/15/93

J. Was the facility purchased or leased after January 1, 1978?

YES Date 5/15/93 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 7/1/13 - 6/30/14 Fiscal Year: 7/1/13 - 6/30/14

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

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	51,272	6,839	1,929	60,040	4,971	65,011	65,011		1	
2	Food Purchase		45,785		45,785		45,785	45,785		2	
3	Housekeeping		6,571		6,571	14,913	21,484	21,484		3	
4	Laundry		6,783		6,783	9,942	16,725	16,725		4	
5	Heat and Other Utilities			25,961	25,961	(5,709)	20,252	20,252		5	
6	Maintenance	4,770	10,198	14,705	29,673		29,673	29,673		6	
7	Other (specify):* TRASH SERVICE					5,709	5,709	5,709		7	
8	TOTAL General Services	56,042	76,176	42,595	174,813	29,826	204,639	204,639		8	
	B. Health Care and Programs										
9	Medical Director			1,200	1,200		1,200	1,200		9	
10	Nursing and Medical Records	406,159	28,199	4,315	438,673	(5,576)	433,097	433,097		10	
10a	Therapy			11,043	11,043		11,043	11,043		10a	
11	Activities	39,163	1,856		41,019	(24,250)	16,769	16,769		11	
12	Social Services			1,560	1,560		1,560	1,560		12	
13	CNA Training	1,008			1,008		1,008	1,008		13	
14	Program Transportation		3,333		3,333		3,333	3,333		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	446,330	33,388	18,118	497,836	(29,826)	468,010	468,010		16	
	C. General Administration										
17	Administrative	22,095			22,095		22,095	22,095		17	
18	Directors Fees									18	
19	Professional Services			36,621	36,621		36,621	36,621		19	
20	Dues, Fees, Subscriptions & Promotions			5,665	5,665		5,665	5,665		20	
21	Clerical & General Office Expenses		7,201		7,201		7,201	7,201		21	
22	Employee Benefits & Payroll Taxes			99,731	99,731		99,731	99,731		22	
23	Inservice Training & Education			741	741		741	741		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			10,922	10,922		10,922	10,922		26	
27	Other (specify):*									27	
28	TOTAL General Administration	22,095	7,201	153,680	182,976		182,976	182,976		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	524,467	116,765	214,393	855,625		855,625	855,625		29	

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

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 CENTRALIA

#0038646

Report Period Beginning:

7/01/2013

Ending:

6/30/2014

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			27,964	27,964		27,964		27,964			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,316	8,316		8,316	(390)	7,926			32
33	Real Estate Taxes			345	345		345		345			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* BOND/TRUSTEE FEES			3,111	3,111		3,111		3,111			36
37	TOTAL Ownership			39,736	39,736		39,736	(390)	39,346			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			54,337	54,337		54,337		54,337			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			54,337	54,337		54,337		54,337			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	524,467	116,765	308,466	949,698		949,698	(390)	949,308			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	390	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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 390		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 390		37

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

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

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

BHF USE ONLY					
48		49	50	51	52

PARK PLACE CENTRALIA

ID# 0038646

Report Period Beginning: 7/01/2013

Ending: 6/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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 CENTRALIA# 0038646

Report Period Beginning:

7/01/2013

Ending:

6/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK PLACE CENTRALIA# 0038646

Report Period Beginning:

7/01/2013 Ending:

6/30/2014

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	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	390	0	0	0	0	0	0	0	0	0	0	390	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	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	390	0	0	0	0	0	0	0	0	0	0	390	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	390	0	0	0	0	0	0	0	0	0	0	390	45

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
		LYNWOOD ESTATES	SALEM			
		COLONIAL APARTMENTS	CENTRALIA			
		DIAMONDVIEW	CENTRALIA			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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								1
2	ALLISON AUSTIN	BOD						2
3	RANDY VOGT	BOD						3
4	GREG REICHENBACHER	BOD						4
5	SHEILA KAPES	BOD						5
6	ELAINE BEHRMANN	BOD						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

Facility Name & ID Number PARK PLACE CENTRALIA # 0038646 Report Period Beginning: 7/01/2013 Ending: 6/30/2014

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 CENTRALIA

0038646

Report Period Beginning:

7/01/2013

Ending: 7/30/2014

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

PARK PLACE CENTRALIA

0038646

Report Period Beginning:

7/01/2013

Ending:

6/30/2014

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	ILL DEV FINANCE AUTHORITY	X		MORTGAGE	APPR5928	7/2/97	\$ 770,400	\$ 138,600	7/1/14	0.0623	\$ 8,316	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 770,400	\$ 138,600			\$ 8,316	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 770,400	\$ 138,600			\$ 8,316	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009	_____	8	FOR BHF USE ONLY		
	2010	_____	9			
	2011	_____	10			
	2012	_____	11			
	2013	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK PLACE CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0038646

CONTACT PERSON REGARDING THIS REPORT RENEE ZIEGLER

TELEPHONE 618 533-9633 FAX #: 618 533-6345

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-00-080-500</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>45.90</u>	\$ <u>45.90</u>
2. <u>14-00-080-505</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>46.96</u>	\$ <u>46.96</u>
3. <u>14-00-080-510</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>55.50</u>	\$ <u>55.50</u>
4. <u>14-00-080-515</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>57.64</u>	\$ <u>57.64</u>
5. <u>14-00-080-520</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>55.50</u>	\$ <u>55.50</u>
6. <u>14-00-080-525</u>	<u>COUNTRY CLUB ROAD SUB LOT</u>	\$ <u>55.50</u>	\$ <u>55.50</u>
7. <u>14-00-080-531</u>	<u>COUNTRY CLUB ROAD SUB PT L</u>	\$ <u>78.98</u>	\$ <u>78.98</u>
8. <u>14-00-080-536</u>	<u>COUNTRY CLUB ROAD SUB PT L</u>	\$ <u>34.16</u>	\$ <u>34.16</u>
9. <u>14-00-080-541</u>	<u>COUNTRY CLUB ROAD SUB PT L</u>	\$ <u>19.22</u>	\$ <u>19.22</u>
10. <u>14-00-080-546</u>	<u>COUNTRY CLUB ROAD SUB PT I</u>	\$ <u>34.16</u>	\$ <u>34.16</u>
TOTALS		\$ <u><u>483.52</u></u>	\$ <u><u>483.52</u></u>

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? X YES NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 CENTRALIA

0038646 Report Period Beginning:

7/01/2013 Ending:

6/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,350 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		50,000	1994	\$ 16,093	1
2			1999	49,883	2
3	TOTALS	50,000		\$ 65,976	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1995	1995	\$ 414,491	\$ 16,580	25	\$ 16,580		\$ 323,348
5										
6										
7										
8										
	Improvement Type**									
9		CARPET/PATIO IMPROVEMENTS	1999	1999	6,449	258	25	258		3,999
10		24 X 32 PAVILLION	1999	1999	17,486	699	25	699		10,140
11		STEEL DOOR	2005	2005	899	36	25	36		325
12		AIR CONDITIONER	2005	2005	1,450	145	10	145		1,317
13		GENERATOR	2008	2008	20,000	2,000	10	2,000		12,333
14		SPRINKLER SYSTEM	2010	2010	5,108	341	15	341		1,391
15		REMODEL - PAINT, CARPET, TILE ETC	1010	1010	69,504	2,780	25	2,780		10,194
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **PARK PLACE CENTRALIA**

0038646

Report Period Beginning:

7/01/2013

Ending:

6/30/2014

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 535,387	\$ 22,839		\$ 22,839	\$	\$ 363,047	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,237	\$ 775	\$ 775	\$	5	\$ 3,118	71
72	Current Year Purchases	12,247	816	816		5	816	72
73	Fully Depreciated Assets	122,061					122,061	73
74								74
75	TOTALS	\$ 139,545	\$ 1,591	\$ 1,591	\$		\$ 125,995	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	PATIENT/ADMIN	2005 GMC SAVANA	2005	\$ 45,494	\$	\$	\$		\$ 45,494	76
77	PATIENT/ADMIN	2003 CHEVY VENTURE	2013	15,305	2,551	2,551		5	2,551	77
78	PATIENT/ADMIN	2014 GMC ACADIA	2014	9,987	499	499		5	499	78
79	PATIENT/ADMIN	2014 GMC TERRAIN	2014	14,509	484	484		5	484	79
80	TOTALS			\$ 85,295	\$ 3,534	\$ 3,534	\$		\$ 49,028	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)	\$ 826,203	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,964	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)	\$ 538,070	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					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ _____ Description: _____

(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.

Facility Name & ID Number PARK PLACE CENTRALIA # 0038646 Report Period Beginning: 7/01/2013 Ending: 6/30/2014
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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>60</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		403		403
4	Clinical Wages (b)		605		605
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,008	\$	\$ 1,008
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,008		

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescrpts							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			\$		\$	\$		\$	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 CENTRALIA**# **0038646**Report Period Beginning: **7/01/2013**

Ending:

6/30/2014**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2014**

(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	\$ 1,275,672	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	385,967		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,237		6
7	Other Prepaid Expenses	8,658		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,674,534	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,406		13
14	Buildings, at Historical Cost	1,701,459		14
15	Leasehold Improvements, at Historical Cost	290,940		15
16	Equipment, at Historical Cost	681,098		16
17	Accumulated Depreciation (book methods)	(1,821,063)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	468,009		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM PENTA GROUP	167,196		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,597,045	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,271,579	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,844	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	385,000		29
30	Accrued Salaries Payable	36,242		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,275		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,550		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 502,911	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 502,911	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,768,668	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,271,579	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,003,757	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,003,757	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(235,089)	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)	\$ (235,089)	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)	\$ 2,768,668	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PARK PLACE CENTRALIA# 0038646Report Period Beginning: 7/01/2013Ending: 6/30/2014

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 796,878	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 796,878	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	1,688	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)	\$ 1,688	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	390	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 390	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	12,950	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,950	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 811,906	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	174,813	31
32	Health Care	497,836	32
33	General Administration	182,976	33
B. Capital Expense			
34	Ownership	39,736	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,337	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 949,698	40
41	Income before Income Taxes (line 30 minus line 40)**	(137,792)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (137,792)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 675,954	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SOCIAL SECURITY & SII</u>	120,924	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 796,878	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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 CENTRALIA**

0038646

Report Period Beginning:

7/01/2013

Ending:

6/30/2014

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				3
4	Licensed Practical Nurses	5,984	91,344	14.09	4
5	CNAs & Orderlies				5
6	CNA Trainees	100	1,008	10.08	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	1,461	14,913	9.56	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	3,582	51,272	13.16	14
15	Cook Helpers/Assistants	487	4,971	9.56	15
16	Dishwashers				16
17	Maintenance Workers	428	4,771	10.24	17
18	Housekeepers	1,461	14,913	9.56	18
19	Laundry	974	9,942	9.56	19
20	Administrator	480	22,095	42.49	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	1,419	32,775	19.25	29
30	Habilitation Aides (DD Homes)	27,084	276,463	9.56	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	43,460	\$ 524,467 *	\$ 11.21	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	27	\$ 1,929	1-3 35
36	Medical Director	12	1,200	9-3 36
37	Medical Records Consultant			37
38	Nurse Consultant	35	2,294	10-3 38
39	Pharmacist Consultant	8	161	10-3 39
40	Physical Therapy Consultant	4	316	10A-3 40
41	Occupational Therapy Consultant	70	5,757	10A-3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	94	4,713	10A-3 43
44	Activity Consultant			44
45	Social Service Consultant	24	1,560	12-3 45
46	Other(specify) <u>PSYCHOLOGIST</u>	3	257	10A-3 46
47	<u>DENTAL/VISION</u>	23	1,860	10-3 47
48				48
49	TOTAL (lines 35 - 48)	300	\$ 20,047	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
GEORGIA MILLER	CEO		\$ 22,095	Workers' Compensation Insurance	\$ 16,217	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,910	Advertising: Employee Recruitment	1,548	
				FICA Taxes	39,643	Health Care Worker Background Check	230	
				Employee Health Insurance	34,060	(Indicate # of checks performed <u>10</u>)		
				Employee Meals		Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		DUES	3,533	
				HOLIDAY PARTIES, FLOWERS, VACCNE		LICENSE & FEES	354	
				RETIREMENT	7,901			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 22,095	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,665		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
			\$				Yellow page advertising ()	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
CATCHALL SERVICES	ADMIN		\$ 32,844			\$	Out-of-State Travel	\$
CRAIN, MILLER & WERNSMAN	LEGAL		280					
GLASS & SHUFFETT	AUDIT		1,950				In-State Travel	
CREATIVE SYSTEMS	COMPUTER		1,397					
S MILLNER	CLERICAL		150				Seminar Expense	
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 36,621	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number PARK PLACE CENTRALIA# 0038646Report Period Beginning: 7/01/2013Ending: 6/30/2014**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. IARF - 3533
- (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? _____
- (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? _____
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,991 Line 10-2
- (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. _____
- (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. \$ 54,337
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? YES 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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 80
d. Have vehicle usage logs been maintained? YES
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: GLASS & SHUFFETT
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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.

PAGE 10A
PARK PLACE - CENTRALIA
IDPH LICENSE NUMBER 0038646

TAX INDEX NUMBER	PROPERTY DESCRIPTION	TOTAL TAX	APPLICABLE TAX
14-00-080-550	COUNTRYU CLUB ROAD SUB LOT 11	\$45.90	\$45.90
14-00-080-555	COUNTRY CLUB ROAD SUB LOT 12	\$52.30	\$52.30
14-00-080-565	COUNTRY CLUB ROAD SUB LOT 14	\$38.42	\$38.42
14-00-080-570	COUNTRY CLUB ROAD SUB LOT 15	\$38.42	\$38.42
14-00080-575	COUNTRY CLUB ROAD SUB LOT 16	\$38.42	\$38.42

B.
50% APPLIES TO PARK PLACE AN 50% APPLIES TO
DIAMONDDVIEW (IDPH LICENSE #038638)

PAGE 21
SECTION C
LEGAL EXPENSES

INVOICE DATE	LAW FIRM	ALLOWABLE AMOUNT	NON- ALLOWABLE AMOUNT	DESCRIPTION OF SERVICES
10/7/2013	CRAIN, MILLER & WERNSMAN, LTD	\$129.50	\$129.50	GENERAL - BOARD MEETING
11/15/2013	HART, SOUTHWORTH &	\$27.07	\$27.07	BOND CO- TRUSTEE
12/3/2013	CRAIN, MILLER & WERNSMAN, LTD	\$34.68	\$34.68	GENERAL - BOARD MEETING
2/4/2014	CRAIN, MILLER & WERNSMAN, LTD	\$26.13	\$26.13	GENERAL - BOARD MEETING
6/3/2014	CRAIN, MILLER & WERNSMAN, LTD	\$62.82	\$62.82	GENERAL - BOARD MEETING

SALARY ALLOCATIONS
 PARK PLACE
 YEAR ENDING 6/30/14

		SALARIES PER GL	%	TOTAL HOURS	VACATIONS HRS, ETC
HOUSEKEEPING	\$0.00	\$0.00	0.00%	0.00	0.00
DIRECT CARE	\$9.05	\$283,047.13	87.85%	31260.02	2057.02
ACTIVITY	\$16.01	\$39,162.80	12.15%	2445.50	81.25
SOC SERVICE	\$0.00	\$0.00	0.00%	0.00	0.00
CLERICAL	\$0.00	\$0.00	0.00%	0.00	0.00
	\$9.56	\$322,209.93	100.00%	33705.52	2138.27

	ALLOC HRS DAY	COST RPT	%	TOTAL HOURS	TOTAL HOURS WORKED
HOUSEKEEPING	6.00	\$14,912.91	4.63%	1560.00	1461.03
ACTIVITY	6.00	\$14,912.91	4.63%	1560.00	1461.03
LAUNDRY	4.00	\$9,941.94	3.09%	1040.00	974.02
COOK HELPER	2.00	\$4,970.97	1.54%	520.00	487.01
DIRECT CARE		\$277,471.20	86.11%	29025.52	27184.16
		\$322,209.93	100.00%	33705.52	31567.25