

		FOR BHF USE					

LL1

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
 STATE OF ILLINOIS
 DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
 FINANCIAL AND STATISTICAL REPORT (COST REPORT)
 FOR LONG-TERM CARE FACILITIES
 (FISCAL YEAR 2010)

<p>I. IDPH License ID Number: <u>0038240</u></p> <p>Facility Name: <u>Harris Place</u></p> <p>Address: <u>209 Harris Road</u> <u>East Peoria</u> <u>61611</u> <small>Number City Zip Code</small></p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: <u>(309) 698-9600</u> Fax # <u>(309) 698-9604</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/01/1992</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <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>07/01/2009</u> to <u>06/30/2010</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 style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Jerry Johnson</u> (Title) <u>Controller</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Michael Kaplan Consultant</u> (Firm Name & Address) _____ (Telephone) <u>(847) 772-7419</u> Fax # ()</td> </tr> </table> <p align="right">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>Jerry Johnson</u> (Title) <u>Controller</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Michael Kaplan Consultant</u> (Firm Name & Address) _____ (Telephone) <u>(847) 772-7419</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>Jerry Johnson</u> (Title) <u>Controller</u>																												
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Michael Kaplan Consultant</u> (Firm Name & Address) _____ (Telephone) <u>(847) 772-7419</u> Fax # ()																												

Facility Name & ID Number Harris Place

0038240 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 N/A

	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 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	<u>4,695</u>			<u>4,695</u>	13
14	TOTALS	<u>4,695</u>			<u>4,695</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.39%

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

105 (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

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 10/1/1992

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

YES Date 03/08/1999 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 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number

Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	13,415	2,261	2,430	18,106		18,106		18,106		1
2	Food Purchase		30,478		30,478		30,478		30,478		2
3	Housekeeping		4,803		4,803		4,803	239	5,042		3
4	Laundry		1,386	560	1,946		1,946		1,946		4
5	Heat and Other Utilities			13,211	13,211		13,211	1,393	14,604		5
6	Maintenance	11,442		8,296	19,738		19,738	875	20,613		6
7	Other (specify):*										7
8	TOTAL General Services	24,857	38,928	24,497	88,282		88,282	2,507	90,789		8
	B. Health Care and Programs										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	172,220	9,925	8,907	191,052		191,052	1	191,053		10
10a	Therapy			794	794		794		794		10a
11	Activities		708		708		708		708		11
12	Social Services			1,800	1,800		1,800		1,800		12
13	CNA Training										13
14	Program Transportation			3,063	3,063		3,063		3,063		14
15	Other (specify):*			107	107		107		107		15
16	TOTAL Health Care and Programs	172,220	10,633	15,331	198,184		198,184	1	198,185		16
	C. General Administration										
17	Administrative										17
18	Directors Fees			2,498	2,498		2,498		2,498		18
19	Professional Services			11,848	11,848		11,848	3,891	15,739		19
20	Dues, Fees, Subscriptions & Promotions			3,670	3,670		3,670	756	4,426		20
21	Clerical & General Office Expenses		3,358	6,035	9,393		9,393	42,453	51,846		21
22	Employee Benefits & Payroll Taxes			34,782	34,782		34,782	6,664	41,446		22
23	Inservice Training & Education			44	44		44		44		23
24	Travel and Seminar			10,276	10,276		10,276	872	11,148		24
25	Other Admin. Staff Transportation			902	902		902	172	1,074		25
26	Insurance-Prop.Liab.Malpractice			2,812	2,812		2,812	1,130	3,942		26
27	Other (specify):*										27
28	TOTAL General Administration		3,358	72,867	76,225		76,225	55,938	132,163		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	197,077	52,919	112,695	362,691		362,691	58,446	421,137		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

Harris Place

#0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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			24,572	24,572		24,572	2,157	26,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,793	44,793		44,793	(2,269)	42,524			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							684	684			34
35	Rent-Equipment & Vehicles			450	450		450	136	586			35
36	Other (specify):*											36
37	TOTAL Ownership			69,815	69,815		69,815	708	70,523			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			36,576	36,576		36,576		36,576			42
43	Other (specify):* Non-Allowable Cos			176,684	176,684		176,684	(176,684)				43
44	TOTAL Special Cost Centers			213,260	213,260		213,260	(176,684)	36,576			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	197,077	52,919	395,770	645,766		645,766	(117,530)	528,236			45

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

Facility Name & ID Number **Harris Place**

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	\$ (180,222)	43	\$	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	(2,560)	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	(1,355)	43		17
18	Fines and Penalties	5,000	43		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	(107)	43		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 <u>See Pg 5A</u>				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (179,244)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	61,714		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,714		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (117,530)		37

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

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

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

Harris Place

ID# 0038240

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

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

Facility Name & ID Number Harris Place

0038240

Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Sch 6A		See Attached Related Party Schedule Sch 6A		
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	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)	
1	V	18 Board Fees	\$ 357	Progressive Housing, Inc.	100.00%	\$ 357	\$	1
2	V	19 Professional Fees	723	Progressive Housing, Inc.	100.00%	723		2
3	V	20 License, Dues	1	Progressive Housing, Inc.	100.00%	1		3
4	V	21 General Office	275	Progressive Housing, Inc.	100.00%	275		4
5	V	23 Inservices Travel		Progressive Housing, Inc.	100.00%			5
6	V	24 Travel Seminar	34	Progressive Housing, Inc.	100.00%	34		6
7	V	32 Interest Income	16	Progressive Housing, Inc.	100.00%	16		7
8	V	43 Non-allowable		Progressive Housing, Inc.	100.00%			8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,406			\$ 1,406	\$ *	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	\$ 2,141	Progressive Housing, Inc.	100.00%	\$ 2,141	\$
16	V	19 Professional Fees	10,440	Progressive Housing, Inc.	100.00%	10,440	
17	V	20 License, Dues	1	Progressive Housing, Inc.	100.00%	1	
18	V	21 General Office	1,951	Progressive Housing, Inc.	100.00%	1,951	
19	V	23 Inservices Travel		Progressive Housing, Inc.	100.00%		
20	V	24 Travel Seminar	258	Progressive Housing, Inc.	100.00%	258	
21	V	32 Interest Income	139	Progressive Housing, Inc.	100.00%	139	
22	V	43 Non-allowable	(73)	Progressive Housing, Inc.	100.00%	(73)	
23	V	24 Travel Seminar	102	Progressive Housing, Inc.	100.00%	102	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 14,959			\$ 14,959	\$ *

* 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	3 <u>Housekeeping</u>	\$	<u>Center For Residential Management</u>	<u>Parent Co.</u>	\$ 239	\$ 239
16	V	5 <u>Utilities</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	1,393	1,393
17	V	6 <u>Maintenance</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	875	875
18	V	10 <u>Nursing Supplies</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	1	1
19	V	17 <u>Administrative Cost</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
20	V	19 <u>Professional Fees</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	3,891	3,891
21	V	20 <u>Dues, Fees</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	756	756
22	V	21 <u>Clerical & General</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	42,453	42,453
23	V	22 <u>Employment Benefits</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	6,664	6,664
24	V	23 <u>Inservices Education</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
25	V	24 <u>Travel Seminar</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	872	872
26	V	25 <u>Other Admin Staff Trans.</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	172	172
27	V	26 <u>Insurance</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	1,130	1,130
28	V	30 <u>Depreciation</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	2,157	2,157
29	V	32 <u>Interest</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	291	291
30	V	33 <u>Real Estate Taxes</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>		
31	V	34 <u>Rent</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	684	684
32	V	35 <u>Equipment Rental</u>		<u>Center For Residential Management</u>	<u>Parent Co.</u>	136	136
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 61,714	\$ * 61,714

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

RELATED PARTY SCHEDULE

Schedule VII - Related Parties

Page 6, Section A, Column 2 Related Facilities

NAME	FACILITY NAME	CITY	STATE
Progressive Housing Inc.	Lakeview Living Center	Chicago	IL
	Sparta Terrace	Sparta	IL
	Ellner Terrace	Evansville	IL
	Taylorville Terrace	Taylorville	IL
Progressive Housing Inc.	Aviston Terrace	Aviston	IL
	Briarbrook Place	East Peoria	IL
	Harris Place	East Peoria	IL
	Joshua Manor	Hoyleton	IL
	Terra Estates	Hoyleton	IL
	Park Place	Pana	IL
	Cardinal	Woodlawn	IL
	Western Gardens	MT. Vernon	IL
	Galaxy	Woodlawn	IL
	Bill Goat Hill	MT. Vernon	IL
	Country Club Hill	Country Club Hills	IL
	Lee street	Country Club Hills	IL
	Baker Street	Country Club Hills	IL
	182nd Street	Country Club Hills	IL
	Osage	Park Forest	IL
	Oakwood	Park Forest	IL
	Blair	Park Forest	IL
	Lowell	Hazelcrest	IL
	Marquette	Park Forest	IL
	Cherry	Park Forest	IL
Luella	Sauk Village	IL	
Olivia	Sauk Village	IL	
Huron	Park Forest	IL	
Wilshire	Park Forest	IL	
Constance	Sauk Village	IL	

Schedule VII - Related Parties

Page 6, Section A, Column 3 Other Related Business Entities

Name	City	Type of Business
Center for Residential Management	Peoria	Management Company
Progressive Housing, Inc.	Peoria	ICF/DD Provider

Facility Name & ID Number

Harris Place

#

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	6,427	3Hrs/MTG	1.00	Dir. Fees	\$ 373	L18,C8	1
2	Shawn Jeffers	Chairman	Board Member	None	7,562	3Hrs/MTG	1.00	Dir. Fees	438	L18,C8	2
3	Edward Childers	Vice Chairman	Board Member	None	10,965	3Hrs/MTG	1.00	Dir. Fees	635	L18,C8	3
4	Robert Bauer	Director	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	4
5	Cora Flota	Director	Board Member	None	1,512	3Hrs/MTG	1.00	Dir. Fees	88	L18,C8	5
6	Orland Bauer	Treasurer	Board Member	None	8,318	3Hrs/MTG	1.00	Dir. Fees	482	L18,C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,498		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

Harris Place
0038240
06/30/2010

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.	Ron Schroder	Edward Childers	Robert Bauer	Cora Flota	Orland Bauer	Shawn Jeffers	Total
Lakeview Living Center	630	1,072	812	150	812	739	4,215
Sparta Terrace	373	635	482	88	482	438	2,498
Ellner Terrace	373	635	482	88	482	438	2,498
Taylorville Terrace	373	635	482	88	482	438	2,498
Aviston Terrace	373	635	482	88	482	438	2,498
Briarbrook Place	373	635	482	88	482	438	2,498
Harris Place	373	635	482	88	482	438	2,498
Joshua Manor	373	635	482	88	482	438	2,498
Terra Estates	373	635	482	88	482	438	2,498
Park Place	373	635	482	88	482	438	2,498
Cardinal	186	318	241	44	241	219	1,249
Western Gardens	186	318	241	44	241	219	1,249
Galaxy	186	318	241	44	241	219	1,249
Bill Goat Hill	186	318	241	44	241	219	1,249
Country Club Hill	140	238	180	33	181	164	936
Lee Street	140	238	180	33	181	164	936
Baker Street	140	238	180	34	180	164	936
182nd Street	140	238	180	34	180	164	936
Osage	140	238	180	34	180	164	936
Oakwood	140	238	180	34	180	164	936
Blair	140	239	180	33	180	164	936
Lowell	140	239	180	33	180	164	936
Marquette	140	239	180	33	180	164	936
Cherry	140	239	180	33	180	164	936
Luella	140	238	181	33	180	164	936
Olivia	140	238	181	33	180	164	936
Huron	141	238	180	33	180	164	936
Wilshire	141	238	180	33	180	164	936
Constance	107	205	164	16	164	147	803
Total PHI	6,800	11,600	8,800	1,600	8,800	8,000	45,600

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

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 Progressive Housing, Inc.
 Street Address PO 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	287	\$ 6,400	\$	16	\$ 357	1
2	19	Professional Fees	Number of Beds	287	12,968		16	723	2
3	20	License, Dues	Number of Beds	287	10		16	1	3
4	21	General Office	Number of Beds	287	4,934		16	275	4
5	23	Inservices Travel	Number of Beds	287			16	0	5
6	24	Travel Seminar	Number of Beds	287	609		16	34	6
7	32	Interest Income	Number of Beds	287	285		16	16	7
8	43	Non-allowable	Number of Beds	287			16	0	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				\$ 25,206	\$		\$ 1,406	25

Facility Name & ID Number Harris Place

0038240

Report Period Beginning: 07/01/2009

Ending: 6/30/2010

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 Progressive Housing, Inc.
 Street Address PO 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	293	\$ 39,200	\$	16	\$ 2,141	1
2	19	Professional Fees	Number of Beds	293	191,187		16	10,440	2
3	20	License, Dues	Number of Beds	293	10		16	1	3
4	21	General Office	Number of Beds	293	35,726		16	1,951	4
5	23	Inservices Travel	Number of Beds	293			16		5
6	24	Travel Seminar	Number of Beds	293	4,722		16	258	6
7	32	Interest Income	Number of Beds	293	2,540		16	139	7
8	43	Non-allowable	Number of Beds	293	(1,344)		16	(73)	8
9	24	Travel Seminar	Number of Facilities	13	1,329		1	102	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				\$ 273,370	\$		\$ 14,959	25

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

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 Management
 Street Address PO 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	3	Housekeeping	Revenue	12,610,469	\$ 4,888	\$	616,368	\$ 239	1
2	5	Utilities	Revenue	12,610,469	28,505		616,368	1,393	2
3	6	Maintenance	Revenue	12,610,469	17,904		616,368	875	3
4	10	Nursing Supplies	Revenue	12,610,469	29		616,368	1	4
5	17	Administrative Cost	Revenue	12,610,469			616,368		5
6	19	Professional Fees	Revenue	12,610,469	79,603		616,368	3,891	6
7	20	Dues, Fees	Revenue	12,610,469	15,474		616,368	756	7
8	21	Clerical & General	Revenue	12,610,469	868,566	741,167	616,368	42,453	8
9	22	Employment Benefits	Revenue	12,610,469	136,351		616,368	6,664	9
10	23	Inservices Education	Revenue	12,610,469			616,368		10
11	24	Travel Seminar	Revenue	12,610,469	17,846		616,368	872	11
12	25	Other Admin Staff Trans.	Revenue	12,610,469	3,527		616,368	172	12
13	26	Insurance	Revenue	12,610,469	23,128		616,368	1,130	13
14	30	Depreciation	Revenue	12,610,469	44,128		616,368	2,157	14
15	32	Interest	Revenue	12,610,469	5,957		616,368	291	15
16	33	Real Estate Taxes	Revenue	12,610,469			616,368		16
17	34	Rent	Revenue	12,610,469	13,987		616,368	684	17
18	35	Equipment Rental	Revenue	12,610,469	2,792		616,368	136	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,262,685	\$ 741,167		\$ 61,714	25

Facility Name & ID Number

Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	Reporting Period Interest Expense					
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO											Original	Balance		
	A. Directly Facility Related																
	Long-Term																
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 692,503	\$ 641,491	08/15/26	6.7500	\$ 43,172	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6	Vendor Finance Charge		X	Working Capital							72	6					
7	Allocation from Parent	X		Working Capital							445	7					
8	Amort of Loan Cost		X	Facility Acquisition							1,395	8					
9	TOTAL Facility Related						\$ 692,503	\$ 641,491			\$ 45,084	9					
	B. Non-Facility Related*																
10												10					
11	Offset Interest Income										(2,560)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (2,560)	14					
15	TOTALS (line 9+line14)						\$ 692,503	\$ 641,491			\$ 42,524	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** 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 2009 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.)	2009	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 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:	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harris Place COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0038240

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Harris Place

0038240

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior Brick/VinylSiding 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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 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>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	47,250		\$ 20,000	3

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250		\$ 206,833	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting		1999		2,183	146	15	146		1,673	9
10	Drive Repaving		2004		1,498	100	15	100		591	10
11	Bathroom Carpet		2006		945	63	15	63		257	11
12	Carpeting		2006		1,558	104	15	104		416	12
13	Bathroom Tile					68		68			13
14	Bathoom Toilets		2006		1,026	68	15	68		262	14
15	Bathroom Remodel		2006		5,100	340	15	340		1,247	15
16	Bathroom Remodel		2006		3,043	203	15	203		727	16
17	Bathroom Remodel		2007		3,355	224	15	224		764	17
18	Gazebo		2007		1,896	126	15	126		326	18
19	Concrete Sidewalk		2009		2,255	150	15	150		188	19
20	Repair the Water Line to Showers		2009		2,562	100	15	100		100	20
21	Bedroom Carpeting		2010		565	3	15	3		3	21
22	Bathroom Remodel		2010		430	2	15	2		2	22
23	Exterior Door for Facility		2010		344	8	15	8		8	23
24											24
25											25
26											26
27											27
28											28
29	Allocation from Parent Company							701	701		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.

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

See Page 12A, Line 70 for total

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)	\$ 756,760	\$ 19,955		\$ 20,656	\$ 701	\$ 213,397	70

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

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	\$ 15,626	\$ 1,643	\$ 1,643	\$	5-10Yrs	\$ 9,108	71
72	Current Year Purchases	922	52	52		5-10Yrs	52	72
73	Fully Depreciated Assets	9,074				5-10Yrs	9,074	73
74	Allocation from Parent Company			1,456	1,456			74
75	TOTALS	\$ 25,622	\$ 1,695	\$ 3,151	\$ 1,456		\$ 18,234	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	2005 Dodge	2005	\$ 14,612	\$ 2,922	\$ 2,922	\$	5	\$ 14,125	76
77										77
78										78
79										79
80	TOTALS			\$ 14,612	\$ 2,922	\$ 2,922	\$		\$ 14,125	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)	\$ 816,994	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,572	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,729	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,157	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 245,756	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.

Facility Name & ID Number Harris Place

0038240

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Parent Company				684			5
6								6
7	TOTAL				\$ 684			7

**

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A N/A.

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

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: \$ 586 Description: Water Softener, Wheel Chair, Allocated from Parent Co. Postage Meter, Lift

(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		<u>N/A</u>			18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2011 \$ N/A

13. _____ /2012 \$ N/A

14. _____ /2013 \$ N/A

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 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	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	L10, C3	visits		22	5,331		22	5,331	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>Podiatry</u>	L10, C3			1	23		1	23	12
13	Other (specify): _____									13
14	TOTAL			\$	23	\$ 5,354	\$	23	\$ 5,354	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 Harris Place

0038240

Report Period Beginning: 07/01/2009

Ending:

06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010

(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	\$ 300	\$ 300	1
2	Cash-Patient Deposits	4,395	4,395	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (10,303))	364,061	364,061	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67	67	6
7	Other Prepaid Expenses	130	130	7
8	Accounts Receivable (owners or related parties)	1,904,483	1,904,483	8
9	Other(specify):	101,183	101,183	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,374,619	\$ 2,374,619	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	756,760	756,760	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	40,234	40,234	16
17	Accumulated Depreciation (book methods)	(245,756)	(245,756)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan Cost</u>)	13,899	13,899	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 585,137	\$ 585,137	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,959,756	\$ 2,959,756	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 92,071	\$ 92,071	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,395	4,395	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,443	7,443	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,148	16,148	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Workshop,Accrued Exp.</u>	133,459	133,459	36
37	<u>Deferred Income</u>	20,194	20,194	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 273,710	\$ 273,710	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	641,491	641,491	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)	\$ 641,491	\$ 641,491	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 915,201	\$ 915,201	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,044,555	\$ 2,044,555	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,959,756	\$ 2,959,756	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,891,171	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,891,171	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	153,384	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)	\$ 153,384	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)	\$ 2,044,555	24 *

* This must agree with page 17, line 47.

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	\$ 616,368	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 616,368	3
B. Ancillary Revenue			
4	Day Care	180,222	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 180,222	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		24
25	Interest and Other Investment Income***	2,560	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,560	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)	\$ 799,150	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	88,282	31
32	Health Care	198,184	32
33	General Administration	76,225	33
B. Capital Expense			
34	Ownership	69,815	34
C. Ancillary Expense			
35	Special Cost Centers	176,684	35
36	Provider Participation Fee	36,576	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 645,766	40
41	Income before Income Taxes (line 30 minus line 40)**	153,384	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 153,384	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	Harris Place
ID#	0038240
FYE	06/30/2010

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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			\$	\$	1
2					2
3	476	566	12,541	22.16	3
4	476	118	3,087	26.16	4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15	1,388	1,501	13,415	8.94	15
16					16
17	865	926	11,442	12.36	17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29	1,478	1,510	20,785	13.76	29
30	14,786	15,425	135,348	8.77	30
31					31
32	46	46	459	9.98	32
33					33
34	19,515	20,092	\$ 197,077 *	\$ 9.81	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	31	\$ 2,430	L1, C3	35
36	Monthly	660	L9, C3	36
37				37
38	87	2,981	L10, C3	38
39	Monthly	572	L10, C3	39
40	6	394	L10A, C3	40
41	5	280	L10A, C3	41
42				42
43	3	120	L10A, C3	43
44				44
45	20	1,800	L12, C3	45
46	Monthly	107	L10, C3	46
47				47
48				48
49	152	\$ 9,344		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	N/A	\$		50
51				51
52				52
53		\$		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
	N/A		\$	Workers' Compensation Insurance		\$ 8,746	IDPH License Fee		\$
N/A Allocated frm CRM				Unemployment Compensation Insurance		4,364	Advertising: Employee Recruitment		2,208
				FICA Taxes		15,225	Health Care Worker Background Check		460
				Employee Health Insurance		5,739	(Indicate # of checks performed <u>46</u>)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Vehicle License		119
				Employee Moral		356	IHCA Dues		883
				403B Retirement Contribution		160			
				Drug Test		192			
							Allocation from Parent Company		756
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)			\$				TOTAL (agree to Sch. V, line 20, col. 8)	\$	4,426
(List each licensed administrator separately.)									
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Allocated from Center For Residential Management									
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
Schuyler Roche	Legal		\$ 139			\$	Out-of-State Travel		\$ 9
Wells Fargo	Bond Trustee		164	N/A					
Krieg, Devault	Legal		2,588						
Personnel Planners	UC Consultant		497				In-State Travel		9,652
Heinold-Banwart, LTD	Accounting		7,590				Allocation from Parent Company		767
Barbara Weiner	Legal		82						
Wildman, Harrold, Allen	Legal		778				Seminar Expense		615
Westervelt, Johnson, Nicoll	Legal		10				Allocation from Parent Company		105
Allocation from Parent Company			3,891				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 15,739	TOTAL		\$	TOTAL		\$ 11,148
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harris Place

Report Period Beginning: 07/01/2009 Ending:

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							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Harris Place# 0038240Report Period Beginning: 07/01/2009Ending: 06/30/2010**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 \$ 883
- (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? N/A If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,591 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. \$ 36,576
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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 97
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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.