FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0038240

Facility Name: Harris Place

Address: 209 Harris Road (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 698-9600 **Fax #** (309) 698-9604

HFS ID Number:

Date of Initial License for Current Owners: 08/01/1992

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 C (3)

In the event there are further questions about this report, please contact:
Name: Jerry Johnson **Telephone Number:** (309) 685-0595 ext 304
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2010 to 6/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jerry Johnson

(Title) Controller

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Lisa Templin, Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525

(Telephone) 309-265-3630 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,727			4,727	13
14	TOTALS	4,727			4,727	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.94%

D. How many bed-hold days during this year were paid by the Department?
58 (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 [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 10/1/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/08/1999 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	25,487	1,763	2,338	29,588		29,588		29,588			1
2	Food Purchase		28,145		28,145		28,145		28,145			2
3	Housekeeping		3,736		3,736		3,736	338	4,074			3
4	Laundry		1,070		1,070		1,070		1,070			4
5	Heat and Other Utilities			12,304	12,304		12,304	507	12,811			5
6	Maintenance	9,361		10,433	19,794		19,794	399	20,193			6
7	Other (specify):*											7
8	**TOTAL General Services**	34,848	34,714	25,075	94,637		94,637	1,244	95,881			8
	B. Health Care and Programs											
9	Medical Director			660	660		660		660			9
10	Nursing and Medical Records	122,157	5,152	7,257	134,566		134,566		134,566			10
10a	Therapy			564	564		564		564			10a
11	Activities		805	2	807		807	440	1,247			11
12	Social Services			1,352	1,352		1,352		1,352			12
13	CNA Training											13
14	Program Transportation			4,110	4,110		4,110		4,110			14
15	Other (specify):*			57	57		57		57			15
16	**TOTAL Health Care and Programs**	122,157	5,957	14,002	142,116		142,116	440	142,556			16
	C. General Administration											
17	Administrative	625			625		625		625			17
18	Directors Fees			2,172	2,172		2,172		2,172			18
19	Professional Services			10,803	10,803		10,803	3,780	14,583			19
20	Dues, Fees, Subscriptions & Promotions			2,397	2,397		2,397	413	2,810			20
21	Clerical & General Office Expenses		2,098	7,610	9,708		9,708	45,255	54,963			21
22	Employee Benefits & Payroll Taxes			41,545	41,545		41,545	9,607	51,152			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,245	3,245		3,245	512	3,757			24
25	Other Admin. Staff Transportation			2,474	2,474		2,474	238	2,712			25
26	Insurance-Prop.Liab.Malpractice			2,692	2,692		2,692	578	3,270			26
27	Other (specify):*											27
28	**TOTAL General Administration**	625	2,098	72,938	75,661		75,661	60,383	136,044			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	157,630	42,769	112,015	312,414		312,414	62,067	374,481			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: 7/1/2010 Ending: 6/30/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,284	22,284		22,284	2,031	24,315			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,827	44,827		44,827	(15,439)	29,388			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			78	78		78	130	208			35
36	Other (specify):*											36
37	**TOTAL Ownership**			67,189	67,189		67,189	(13,278)	53,911			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			33,900	33,900		33,900		33,900			42
43	Other (specify):* Non-allowable Costs			174,004	174,004		174,004	(174,004)				43
44	**TOTAL Special Cost Centers**			207,904	207,904		207,904	(174,004)	33,900			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	157,630	42,769	387,108	587,507		587,507	(125,215)	462,292			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:** 7/1/2010 **Ending:** 6/30/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$ (163,396)	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	(15,771)	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	(608)	43		17
18	Fines and Penalties	(10,000)	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				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)**	$ (189,775)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	64,560		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 64,560		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,215)		37

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

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

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

Harris Place

ID# 0038240

Report Period Beginning: 7/1/2010

Ending: 6/30/2011

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harris Place # 0038240 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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	338	0	0	0	0	0	0	0	0	338	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	507	0	0	0	0	0	0	0	0	507	5
6	Maintenance	0	0	399	0	0	0	0	0	0	0	0	399	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	1,244	0	0	0	0	0	0	0	0	1,244	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	440	0	0	0	0	0	0	0	0	440	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	440	0	0	0	0	0	0	0	0	440	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	3,780	0	0	0	0	0	0	0	0	3,780	19
20	Fees, Subscriptions & Promotions	0	0	413	0	0	0	0	0	0	0	0	413	20
21	Clerical & General Office Expenses	0	0	45,255	0	0	0	0	0	0	0	0	45,255	21
22	Employee Benefits & Payroll Taxes	0	0	9,607	0	0	0	0	0	0	0	0	9,607	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	512	0	0	0	0	0	0	0	0	512	24
25	Other Admin. Staff Transportation	0	0	238	0	0	0	0	0	0	0	0	238	25
26	Insurance-Prop.Liab.Malpractice	0	0	578	0	0	0	0	0	0	0	0	578	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	60,383	0	0	0	0	0	0	0	0	60,383	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	62,067	0	0	0	0	0	0	0	0	62,067	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harris Place **#** 0038240 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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	2,031	0	0	0	0	0	0	0	0	2,031	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,771)	0	332	0	0	0	0	0	0	0	0	(15,439)	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	130	0	0	0	0	0	0	0	0	130	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,771)	0	2,493	0	0	0	0	0	0	0	0	(13,278)	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):*	(174,004)	0	0	0	0	0	0	0	0	0	0	(174,004)	43
44	**TOTAL Special Cost Centers**	(174,004)	0	0	0	0	0	0	0	0	0	0	(174,004)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(189,775)	0	64,560	0	0	0	0	0	0	0	0	(125,215)	45

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$ 939	Progressive Housing, Inc.	100.00%	$ 939	$	1
2	V	11	Activities	269	Progressive Housing, Inc.	100.00%	269		2
3	V	18	Director Fees	2,172	Progressive Housing, Inc.	100.00%	2,172		3
4	V	19	Professional Services	9,754	Progressive Housing, Inc.	100.00%	9,754		4
5	V	20	Dues, Fees, Subs and Promotions	657	Progressive Housing, Inc.	100.00%	657		5
6	V	21	Clerical and General Office	2,774	Progressive Housing, Inc.	100.00%	2,774		6
7	V	24	Travel and Seminar	476	Progressive Housing, Inc.	100.00%	476		7
8	V	32	Interest	143	Progressive Housing, Inc.	100.00%	143		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 17,184			$ 17,184	$ *	14

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	$	Center For Residential Management	Parent Co.	$ 338	$ 338	15
16	V	5	Utilities		Center For Residential Management	Parent Co.	507	507	16
17	V	6	Maintenance		Center For Residential Management	Parent Co.	399	399	17
18	V	11	Activities		Center For Residential Management	Parent Co.	440	440	18
19	V	19	Professional Services		Center For Residential Management	Parent Co.	3,780	3,780	19
20	V	20	Dues, Fees, Subs & Promotions		Center For Residential Management	Parent Co.	413	413	20
21	V	21	Clerical and General Office		Center For Residential Management	Parent Co.	45,255	45,255	21
22	V	22	Employee Benefits & Payroll		Center For Residential Management	Parent Co.	9,607	9,607	22
23	V	23	Inservice Training & Education		Center For Residential Management	Parent Co.	0		23
24	V	24	Travel and Seminar		Center For Residential Management	Parent Co.	512	512	24
25	V	25	Other Admin. Staff Transport.		Center For Residential Management	Parent Co.	238	238	25
26	V	26	Insurance-Prop./Liab./Malprac.		Center For Residential Management	Parent Co.	578	578	26
27	V	30	Depreciation		Center For Residential Management	Parent Co.	2,031	2,031	27
28	V	32	Interest		Center For Residential Management	Parent Co.	332	332	28
29	V	35	Rent-Equipment & Vehicles		Center For Residential Management	Parent Co.	130	130	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 64,560	$ * 64,560	39

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Center for Residential			1
2			Ellner Terrace	Evansville	Management	Peoria	Management Co.	2
3			Taylorville Terrace	Taylorville	Progressive			3
4			Aviston Terrace	Aviston	Housing, Inc.	Peoria	ICF/DD Provider	4
5			Briarbrook Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Steger	Workshop	6
7			Terra Estates	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Waltonville	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,046	3Hrs/MTG	1.00	Dir. Fees	$ 554	L18,C3	1
2	Orland Bauer	Treasurer	Board Member	None	9,046	3Hrs/MTG	1.00	Dir. Fees	554	L18,C3	2
3	Robert Bauer	Secretary	Board Member	None	9,045	3Hrs/MTG	1.00	Dir. Fees	555	L18,C3	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,291	3Hrs/MTG	1.00	Dir. Fees	509	L18,C3	4
5	Lawrence Manson	President	Board Memb/CEO	None	152,116	1.18	2.95	Salary	7,972	L21,C7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,144		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
6/30/2011

SCHEDULE 7A

	BOARD OF DIRECTOR FEES					SALARY
	Progressive Housing, Inc.					Center for Residential Management
	Edward Childers	Orland Bauer	Robert Bauer	Shawn Jeffers	Total	Larry Manson
Lakeview Living Center						4,603
Sparta Terrace	555	555	555	509	2,174	8,156
Ellner Terrace	564	564	563	517	2,208	7,950
Taylorville Terrace	525	525	526	482	2,058	8,624
Aviston Terrace	611	611	611	560	2,393	8,734
Briarbrook Place	579	579	578	531	2,267	9,284
Harris Place	554	554	555	509	2,172	7,972
Joshua Manor	606	606	606	557	2,375	8,283
Terra Estates	646	646	645	592	2,529	8,910
Park Place	471	471	472	433	1,847	7,269
Western Gardens	229	229	229	211	898	3,263
Galaxy	232	232	232	212	908	4,557
Cardinal	204	204	204	187	799	3,545
Bill Goat Hill	234	234	234	215	917	4,328
Country Club Hill	181	181	182	167	711	3,482
Lee Street	199	199	198	182	778	3,576
Baker Street	193	193	192	177	755	3,644
182nd Street	202	202	202	186	792	3,684
Osage	212	212	213	195	832	3,683
Oakwood	206	206	205	189	806	3,779
Blair	210	210	211	193	824	3,847
Lowell	251	251	252	231	985	3,904
Marquette	208	208	207	191	814	4,037
Cherry	223	223	222	204	872	4,170
Luella	238	238	238	219	933	4,125
Olivia	240	240	241	222	943	4,464
Huron	217	217	217	199	850	4,039
Wilshire	213	213	213	195	834	4,239
Constance	166	166	166	145	643	1,417
175th Place	211	211	212	189	823	3,094
Sauganash						177
Steger						1,913
Waltonville	220	220	219	201	860	3,174
Perfection Cleaning						162
Total PHI	9,600	9,600	9,600	8,800	37,600	160,088

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: PO Box 10528
City / State / Zip Code: Peoria, IL. 61612
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Budgeted Revenue	14,012,681	30	$ 16,403	$	796,206	$ 939	1
2	11	Activities	Budgeted Revenue	14,012,681	30	4,740		796,206	269	2
3	18	Director Fees	Budgeted Revenue	14,012,681	30	37,600		796,206	2,172	3
4	19	Professional Services	Budgeted Revenue	14,012,681	30	170,531		796,206	9,754	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Revenue	14,012,681	30	11,434		796,206	657	5
6	21	Clerical and General Office	Budgeted Revenue	14,012,681	30	48,267		796,206	2,774	6
7	24	Travel and Seminar	Budgeted Revenue	14,012,681	30	8,382		796,206	476	7
8	32	Interest	Budgeted Revenue	14,012,681	30	2,492		796,206	143	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					$ 299,849	$		$ 17,184	25

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Revenue	12,359,018	34	$ 6,784	$	615,447	$ 338	1
2	5	Utilities	Revenue	12,359,018	34	10,175		615,447	507	2
3	6	Maintenance	Revenue	12,359,018	34	8,009		615,447	399	3
4	11	Activities	Revenue	12,359,018	34	8,842		615,447	440	4
5	19	Professional Services	Revenue	12,359,018	34	75,898		615,447	3,780	5
6	20	Dues, Fees, Subs & Promotions	Revenue	12,359,018	34	8,284		615,447	413	6
7	21	Clerical and General Office	Revenue	12,359,018	34	908,778	829,663	615,447	45,255	7
8	22	Employee Benefits & Payroll	Revenue	12,359,018	34	192,921		615,447	9,607	8
9	23	Inservice Training & Education	Revenue	12,359,018	34	8		615,447		9
10	24	Travel and Seminar	Revenue	12,359,018	34	10,280		615,447	512	10
11	25	Other Admin. Staff Transport.	Revenue	12,359,018	34	4,786		615,447	238	11
12	26	Insurance-Prop./Liab./Malprac.	Revenue	12,359,018	34	11,606		615,447	578	12
13	30	Depreciation	Revenue	12,359,018	34	40,795		615,447	2,031	13
14	32	Interest	Revenue	12,359,018	34	6,672		615,447	332	14
15	35	Rent-Equipment & Vehicles	Revenue	12,359,018	34	2,604		615,447	130	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,296,442	$ 829,663		$ 64,560	25

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	$ 692,503	$ 622,019	08/15/26	6.7500	$ 43,201	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Vendor Finance Charge		X	Working Capital							124	6
7	Allocation from Parent Co.	X		Working Capital							445	7
8	Amort of Loan Cost		X	Line of Credit Fee							1,389	8
9	TOTAL Facility Related						$ 692,503	$ 622,019			$ 45,159	9
	B. Non-Facility Related*											
10												10
11	Offset Interest Income										(15,771)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15,771)	14
15	TOTALS (line 9+line14)						$ 692,503	$ 622,019			$ 29,388	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.)**

Facility Name & ID Number Harris Place # 0038240 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2010**	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 7/1/2010 Ending: 6/30/2011

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	47,250	1999	$ 20,000	1
2					2
3	TOTALS	47,250		$ 20,000	3

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	$ 730,000	$ 18,250	40	$ 18,250	$	$ 225,083	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1999	2,183	146	15	146		1,819	9
10	Drive Repaving			2004	1,498	100	15	100		691	10
11	Bathroom Carpet			2006	945	63	15	63		320	11
12	Carpeting			2006	1,558	104	15	104		520	12
13	Batheoom Toilets			2006	1,026	68	15	68		330	13
14	Bathroom Remodel			2006	5,100	340	15	340		1,587	14
15	Bathroom Remodel			2006	3,043	203	15	203		930	15
16	Bathroom Remodel			2007	3,355	224	15	224		988	16
17	Gazebo			2007	1,896	126	15	126		452	17
18	Concrete Sidewalk			2009	2,255	150	15	150		338	18
19	Repair the Water Line to Showers			2009	2,562	170	15	170		270	19
20	Bedroom Carpeting			2010	565	38	15	38		41	20
21	Bathroom Remodel			2010	430	29	15	29		31	21
22	Exterior Door for Facility			2010	344	23	15	23		31	22
23	Replace air compressor in sprinkler system			2011	1,250	7	15	7		7	23
24	100 Gallon Hot Water Heater			2011	5,605		10	280	280	280	24
25											25
26											26
27											27
28											28
29	Allocation from Parent Company							650	650		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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									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)		$ 763,615	$ 20,041		$ 20,971	$ 930	$ 233,718	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: 7/1/2010 Ending: 6/30/2011

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	$ 11,665	$ 1,430	$ 1,430	$	5-10Yrs	$ 6,351	71
72	Current Year Purchases	498	326	46	(280)	10Yrs	46	72
73	Fully Depreciated Assets	10,375				5-10Yrs	10,375	73
74	Allocated From Parent Co.			1,381	1,381			74
75	TOTALS	$ 22,538	$ 1,756	$ 2,857	$ 1,101		$ 16,772	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trans	2005 Dodge	2005	$ 14,612	$ 487	487	$	5	$ 14,612	76
77										77
78										78
79										79
80	TOTALS			$ 14,612	$ 487	$ 487	$		$ 14,612	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)	$ 820,765	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,284	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,315	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,031	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 265,102	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	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$ N/A
13.	/2013	$ N/A
14.	/2014	$ N/A

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 208 Description: Wheelchair; Allocated from Parent Co - postage machine, copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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	10(3)	visits		11	1,203		11	1,203	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			$	11	$ 1,203	$	11	$ 1,203	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.

STATE OF ILLINOIS

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (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	5,579	5,579	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,303)	198,234	198,234	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67	67	6
7	Other Prepaid Expenses	305	305	7
8	Accounts Receivable (owners or related parties)	2,205,443	2,205,443	8
9	Other(specify):	102,107	102,107	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,512,035	$ 2,512,035	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	758,010	763,615	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,755	37,150	16
17	Accumulated Depreciation (book methods)	(265,102)	(265,102)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Cost	12,539	12,539	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 568,202	$ 568,202	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,080,237	$ 3,080,237	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,857	$ 76,857	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,579	5,579	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,934	10,934	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	16,654	16,654	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Workshop, Accrued Exp.	75,952	75,952	36
37	Deferred Income	17,657	17,657	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 203,633	$ 203,633	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	622,019	622,019	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)**	$ 622,019	$ 622,019	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 825,652	$ 825,652	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,254,585	$ 2,254,585	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,080,237	$ 3,080,237	48

*(See instructions.)

Facility Name & ID Number Harris Place **#** 0038240 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,044,555	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,044,555	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	210,030	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)**	$ 210,030	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)**	$ 2,254,585	24 *

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 615,447	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 615,447	3
	B. Ancillary Revenue		
4	Day Care	163,396	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 163,396	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 **DSP Training**	1,711	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,711	23
	D. Non-Operating Revenue		
24	Contributions	1,212	24
25	Interest and Other Investment Income***	15,771	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,983	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)**	$ 797,537	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	94,637	31
32	Health Care	142,116	32
33	General Administration	75,661	33
	B. Capital Expense		
34	Ownership	67,189	34
	C. Ancillary Expense		
35	Special Cost Centers	174,004	35
36	Provider Participation Fee	33,900	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 587,507	40
41	**Income before Income Taxes (line 30 minus line 40)****	210,030	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 210,030	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 6/30/2011

SCH 19A

Schedule XVII
Page 19

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	41	41	574	14.00	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,599	2,779	25,487	9.17	15
16	Dishwashers					16
17	Maintenance Workers	758	818	9,361	11.44	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	40	40	625	15.63	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)	161	195	2,647	13.57	28
29	Resident Services Coordinator	1,584	1,624	20,118	12.39	29
30	Habilitation Aides (DD Homes)	10,686	11,233	98,818	8.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	15,869	16,730	$ 157,630 *	$ 9.42	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	28	$ 2,270	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	168	5,119	L10, C3	38
39	Pharmacist Consultant	Monthly	935	L10, C3	39
40	Physical Therapy Consultant	4	259	L10A, C3	40
41	Occupational Therapy Consultant	1	65	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	240	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	16	1,352	L12, C3	45
46	Other(specify) Psychiatrist Cons	1	57	L15, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	$ 10,957		49

C. CONTRACT NURSES

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 625
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 625

B. Administrative - Other

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

Vendor/Payee	Type	Amount
Schuyler Roche	Legal	$ 800
Wells Fargo	Bond Trustee	264
Mike Kaplan	Financial Consulting	172
Personnel Planners	UC Consultant	358
Heinold-Banwart, LTD	Accounting	5,031
Barbara Weiner	Legal	57
Wildman, Harrold, Allen	Legal	2,714
Dean Group Consulting	HR Consultant	205
Ice Miller	Legal	142
Westervelt, Johnson, Nicoll & Keller	Legal	1,060
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,803

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,863
Unemployment Compensation Insurance	6,268
FICA Taxes	11,306
Employee Health Insurance	19,839
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Moral	200
Drug Tests	69
Allocation from Parent Co.	9,607
TOTAL (agree to Schedule V, line 22, col.8)	$ 51,152

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	342
Health Care Worker Background Check	
(Indicate # of checks performed 13)	450
Patient Background Checks	
Vehicle License	39
IHCA Dues	368
Miscellaneous Dues & Fees	771
Therapy License	427
Allocation from Parent Co.	413
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,810

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,131
Allocation from Parent Co.	457
Seminar Expense	114
Allocation from Parent Co.	55
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,757

**See instructions.

Harris Place
0038240
Period Beginning 7/1/2010
Period End 6/30/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		10,803

CRM Management Allocation

National Hotline Services	Employee Hotline	90
Mike Kaplan	Finanacial Consultant	3,002
Klancic Architect PC	Architect	68
Title Professionals	Loan Settlement fees	620
Total (agree to Schedule V, line 19, column 8)		14,583

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	Amount of Expense Amortized Per Year								
					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 # 0038240 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 $368**

(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. $ **1,641** 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. $ **33,900**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	25,487	1,763	2,338	29,588	0	29,588	0	29,588
2. Food Purchase	0	28,145	0	28,145	0	28,145	0	28,145
3. Housekeeping	0	3,736	0	3,736	0	3,736	338	4,074
4. Laundry	0	1,070	0	1,070	0	1,070	0	1,070
5. Heat and Other Utilities	0	0	12,304	12,304	0	12,304	507	12,811
6. Maintenance	9,361	0	10,433	19,794	0	19,794	399	20,193
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	34,848	34,714	25,075	94,637	0	94,637	1,244	95,881
9. Medical Director	0	0	660	660	0	660	0	660
10. Nursing & Medical Records	122,157	5,152	7,257	134,566	0	134,566	0	134,566
10a. Therapy	0	0	564	564	0	564	0	564
11. Activities	0	805	2	807	0	807	440	1,247
12. Social Services	0	0	1,352	1,352	0	1,352	0	1,352
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	4,110	4,110	0	4,110	0	4,110
15. Other (specify)*	0	0	57	57	0	57	0	57
16. Total Health Care & Programs	122,157	5,957	14,002	142,116	0	142,116	440	142,556
17. Administrative	625	0	0	625	0	625	0	625
18. Directors Fees	0	0	2,172	2,172	0	2,172	0	2,172
19. Professional Services	0	0	10,803	10,803	0	10,803	3,780	14,583
20. Fees, Subscriptions & Promotion	0	0	2,397	2,397	0	2,397	413	2,810
21. Clerical & General Office	0	2,098	7,610	9,708	0	9,708	45,255	54,963
22. Employee Benefits & Payroll	0	0	41,545	41,545	0	41,545	9,607	51,152
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,245	3,245	0	3,245	512	3,757
25. Other Admin. Staff Trans	0	0	2,474	2,474	0	2,474	238	2,712
26. Insurance-Prop.Liab.Malpractice	0	0	2,692	2,692	0	2,692	578	3,270
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	625	2,098	72,938	75,661	0	75,661	60,383	136,044
29. Total General Administrative	157,630	42,769	112,015	312,414	0	312,414	62,067	374,481
30. Depreciation	0	0	22,284	22,284	0	22,284	2,031	24,315
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	44,827	44,827	0	44,827	-15,439	29,388
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	78	78	0	78	130	208
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	67,189	67,189	0	67,189	-13,278	53,911
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	33,900	33,900	0	33,900	0	33,900
43. Other (specify):*	0	0	174,004	174,004	0	174,004	-174,004	0
44. Total Special Cost Ce	0	0	207,904	207,904	0	207,904	-174,004	33,900
45. Grand Total	157,630	42,769	387,108	587,507	0	587,507	-125,215	462,292

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	300	300
2. Cash - Patient Deposits	5,579	5,579
3. Accounts & Notes Recievable	198,234	198,234
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	67	67
7. Other Prepaid Expenses	305	305
8. Accounts Receivable-Owner/Related Party	2,205,443	2,205,443
9. Other (specify):	102,107	102,107
10. Total current assets	2,512,035	2,512,035
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	758,010	763,615
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	42,755	37,150
17. Accumulated Depreciation (book methods)	-265,102	-265,102
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	12,539	12,539
23. other (specify):	0	0
24. Total Long-Term Assets	568,202	568,202
25. Total Assets	3,080,237	3,080,237
CURRENT LIABILITIES		
26. Accounts Payable	76,857	76,857
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	5,579	5,579
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	10,934	10,934
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	16,654	16,654
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	75,952	75,952
37. Other Current Liabilities (specify):	17,657	17,657
38. Total Current Liabilities	203,633	203,633
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	622,019	622,019
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	622,019	622,019
46.Total Liabilities	825,652	825,652
47.Total Equity	2,254,585	2,254,585
48.Total Liabilities and Equity	3,080,237	3,080,237

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	615,447
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	615,447
4. Day Care	163,396
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	163,396
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	1,711
22. Laundry	0
Subtotal - Other Operating Revenue	1,711
24. Contributions	1,212
25. Interest and Other Investments Income	15,771
Subtotal - Non-Operating Revenue	16,983
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	797,537
31. General Services	94,637
32. Health Care	142,116
33. General Administration	75,661
34. Ownership	67,189
35. Special Cost Centers	164,004
35. Provider Participation Fee	33,900
37. Other	0
40. Total Expenses	577,507
41. Income Before Income Taxes	220,030
42. Income Taxes	0
43. Net Income or Loss for the Year	220,030