FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2015 to 6/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Lawrence A. Manson
(Title) Chief Executive Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,888			4,888	13
14	TOTALS	4,888			4,888	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.47%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 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 _____ and days of care provided _____

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: 6/30/2016 Fiscal Year: 6/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	16,904	1,791	1,717	20,412		20,412		20,412			1
2	Food Purchase		21,713		21,713		21,713		21,713			2
3	Housekeeping		2,231		2,231		2,231		2,231			3
4	Laundry		1,756		1,756		1,756		1,756			4
5	Heat and Other Utilities			17,069	17,069		17,069	3	17,072			5
6	Maintenance	7,202	2,116	6,479	15,797		15,797	15	15,812			6
7	Other (specify):*											7
8	**TOTAL General Services**	24,106	29,607	25,265	78,978		78,978	18	78,996			8
	B. Health Care and Programs											
9	Medical Director			660	660		660		660			9
10	Nursing and Medical Records	164,322	4,429	989	169,740		169,740		169,740			10
10a	Therapy											10a
11	Activities		1,144		1,144		1,144		1,144			11
12	Social Services			1,259	1,259		1,259		1,259			12
13	CNA Training											13
14	Program Transportation			4,156	4,156		4,156		4,156			14
15	Other (specify):*			448	448		448		448			15
16	**TOTAL Health Care and Programs**	164,322	5,573	7,512	177,407		177,407		177,407			16
	C. General Administration											
17	Administrative	22,876		552,742	575,618		575,618	(552,742)	22,876			17
18	Directors Fees							4,390	4,390			18
19	Professional Services			3,057	3,057		3,057	10,402	13,459			19
20	Dues, Fees, Subscriptions & Promotions			1,120	1,120		1,120	2,777	3,897			20
21	Clerical & General Office Expenses	2,742	1,905	11,641	16,288		16,288	70,542	86,830			21
22	Employee Benefits & Payroll Taxes			56,314	56,314		56,314	10,901	67,215			22
23	Inservice Training & Education			194	194		194		194			23
24	Travel and Seminar			702	702		702	1,489	2,191			24
25	Other Admin. Staff Transportation			1,825	1,825		1,825	995	2,820			25
26	Insurance-Prop.Liab.Malpractice			6,044	6,044		6,044	313	6,357			26
27	Other (specify):*											27
28	**TOTAL General Administration**	25,618	1,905	633,639	661,162		661,162	(450,933)	210,229			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	214,046	37,085	666,416	917,547		917,547	(450,915)	466,632			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Harris Place #0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			23,353	23,353		23,353	2,519	25,872			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,122	32,122		32,122	11,806	43,928			32
33	Real Estate Taxes			2	2		2	(2)				33
34	Rent-Facility & Grounds			56	56		56	(56)				34
35	Rent-Equipment & Vehicles							2,718	2,718			35
36	Other (specify):*											36
37	**TOTAL Ownership**			55,533	55,533		55,533	16,985	72,518			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,188		2,188		2,188		2,188			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,245	33,245		33,245		33,245			42
43	Other (specify):* Disallowed Costs			1,646	1,646		1,646	(1,646)				43
44	**TOTAL Special Cost Centers**		2,188	34,891	37,079		37,079	(1,646)	35,433			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	214,046	39,273	756,840	1,010,159		1,010,159	(435,576)	574,583			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(81)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,565)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(433,930)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (435,576)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (435,576)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Harris Place

ID# 0038240

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO Costs	$ (433,872)	43	1
2	Offset rental income against expense	(56)	34	2
3	Disallow Real Estate Taxes	(2)	33	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
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31				31
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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**	(433,930)		49

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	5	Utilities	$	Progressive Housing, Inc.	100.00%	$ 3	$ 3	1
2	V	6	Maintenance		Progressive Housing, Inc.	100.00%	15	15	2
3	V	17	Administrative	552,742	Progressive Housing, Inc.	100.00%		(552,742)	3
4	V	18	Director Fees		Progressive Housing, Inc.	100.00%	4,390	4,390	4
5	V	19	Professional Services		Progressive Housing, Inc.	100.00%	10,402	10,402	5
6	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	2,777	2,777	6
7	V	21	Clerical and General Office	14	Progressive Housing, Inc.	100.00%	70,556	70,542	7
8	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	10,901	10,901	8
9	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	1,489	1,489	9
10	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	995	995	10
11	V	26	Insurance		Progressive Housing, Inc.	100.00%	313	313	11
12	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,519	2,519	12
13	V	32	Interest	2,591	Progressive Housing, Inc.	100.00%	14,397	11,806	13
14	Total			$ 555,347			$ 118,757	$ * (436,590)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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						$	$	15
16	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,718	2,718	16
17	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	433,872	433,872	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 436,590	$ * 436,590	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Aviston Terrace	Aviston	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates-closed	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	9,031	3Hrs/MTG	1.00	Dir. Fees	$ 569	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	9,031	3Hrs/MTG	1.00	Dir. Fees	569	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,983		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Harris Place
0038240
6/30/2016

SCHEDULE 7A

BOARD OF DIRECTOR FEES

Progressive Housing, Inc.

	Cora Flota	Edward Childers	Edward Copeland	Orland Bauer	Robert Bauer	Shawn Jeffers	Eileen Mullin	Misc Exp	Total
Sparta Terrace	569	569	569	569	569	569	569	405	4,390
Ellner Terrace	569	569	569	569	569	569	569	405	4,390
Taylorville Terrace	569	569	569	569	569	569	569	405	4,390
Aviston Terrace	569	569	569	569	569	569	569	405	4,390
Briarbrook Place	569	569	569	569	569	569	569	405	4,390
Harris Place	569	569	569	569	569	569	569	405	4,390
Joshua Manor	569	569	569	569	569	569	569	405	4,390
Terra Estates								157	157
Park Place	569	569	569	569	569	569	569	405	4,390
Western Gardens	249	249	249	249	249	249	249	(27)	1,713
Galaxy	284	284	284	284	284	284	284	(32)	1,957
Cardinal	284	284	284	284	284	284	284	(32)	1,957
Bill Goat Hill	284	284	284	284	284	284	284	(32)	1,957
Country Club Hill	213	213	213	213	213	213	213	151	1,643
Lee Street	213	213	213	213	213	213	213	151	1,643
Baker Street	213	213	213	213	213	213	213	151	1,643
182nd Street	213	213	213	213	213	213	213	151	1,643
Osage	213	213	213	213	213	213	213	151	1,643
Oakwood	213	213	213	213	213	213	213	151	1,643
Blair	-	-	-	-	-	-	-	318	318
Lowell	249	249	249	249	249	249	249	177	1,917
Marquette	249	249	249	249	249	249	249	177	1,917
Cherry	213	213	213	213	213	213	213	151	1,643
Luella	284	284	284	284	284	284	284	202	2,191
Olivia	249	249	249	249	249	249	249	177	1,917
Huron	213	213	213	213	213	213	213	151	1,643
Wilshire	249	249	249	249	249	249	249	177	1,917
Constance	284	284	284	284	284	284	284	193	2,182
175th Place	249	249	249	249	249	249	249	178	1,918
Sauganash	180	180	180	180	180	180	180	126	1,383
Steger	249	249	249	249	249	249	249	177	1,917
Waltonville	-	-	-	-	-	-	-	244	244
Mt. Vernon	-	-	-	-	-	-	-	388	388
Total BOD Expense	**9,600**	**9,600**	**9,600**	**9,600**	**9,600**	**9,600**	**9,600**	**7,016**	**74,216**

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Progressive Housing, Inc.
Street Address: 20180 Governors Dr., Suite 300
City / State / Zip Code: Olympia Fields, IL 60461
Phone Number: (708) 283-1530
Fax Number: (708) 283-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed Capacity/Specific Alloc.	270	29	47		16	$ 3	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	270	29	258		16	15	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	270	29	74,216		16	4,390	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	270	29	180,145		16	10,402	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	270	29	49,923		16	2,777	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	270	29	1,229,303	1,076,524	16	70,556	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	270	29	193,338		16	10,901	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	270	29	27,210		16	1,489	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	270	29	17,338		16	995	9
10	26	Insurance	Bed Capacity/Specific Alloc.	270	29	7,498		16	313	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	270	29	43,850		16	2,519	11
12	32	Interest	Bed Capacity/Specific Alloc.	270	29	250,479		16	14,397	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	270	29	41,954		16	2,718	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	270	29	4,719,330		16	433,872	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,834,889	$ 1,076,524		$ 555,347	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	$ 945,517	$ 774,137	08/15/26	6.7500	$ 30,648	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amortization										1,474	6
7	Allocation from Home Office-Interest										13,669	7
8	Allocation from Home Office-Amortization										728	8
9	TOTAL Facility Related						$ 945,517	$ 774,137			$ 46,519	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset-HO			(2,591)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,591)	14
15	TOTALS (line 9+line14)						$ 945,517	$ 774,137			$ 43,928	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Harris Place # 0038240 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	**2015**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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:			
	2011		**8**
	2012		**9**
	2013		**10**
	2014		**11**
	2015		**12**

N/A - Not for profit entity

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harris Place COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0038240

CONTACT PERSON REGARDING THIS REPORT Lawrence Manson

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/1/2015 Ending: 6/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior Brick/Vinyl Siding Frame Wood Number of Stories One

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	47,250	1999	$ 20,000	1
2	Allocated from Home Office			6,657	2
3	TOTALS	47,250		$ 26,657	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	$	$ 316,364	4
5				2013	(39,426)	(986)	40	(986)		(16,510)	5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1999	2,183		15			2,183	9
10	Drive Repaving			2004	1,498	100	15	100		1,191	10
11	Bathroom Carpet			2006	945	63	15	63		635	11
12	Carpeting (Replaced-See Line 28 below)			2006			15				12
13	Batheoom Toilets			2006	1,026	68	15	68		672	13
14	Bathroom Remodel			2006	5,100	340	15	340		3,287	14
15	Bathroom Remodel			2006	3,043	203	15	203		1,945	15
16	Bathroom Remodel			2007	3,355	224	15	224		2,108	16
17	Gazebo			2007	1,896	126	15	126		1,082	17
18	Concrete Sidewalk			2009	2,255	150	15	150		1,088	18
19	Repair the Water Line to Showers			2009	2,562	171	15	171		1,122	19
20	Bedroom Carpeting			2010	565	38	15	38		231	20
21	Bathroom Remodel			2010	430	29	15	29		176	21
22	Exterior Door for Facility			2010	344	23	15	23		146	22
23	Replace air compressor in sprinkler system			2011	1,250	49	15	49		388	23
24	100 Gallon Hot Water Heater			2011	5,605	374	15	374		2,150	24
25	Furnace Inducer			2012	742	49	15	49		223	25
26	Flooring-Women's Bathroom			2013	516	34	15	34		100	26
27	Replace Dry System Piping with Galvanized Piping			2014	4,903	327	15	327		817	27
28	Carpeting - Living Room, Activity Room and Small Office			2014	1,750	117	15	117		244	28
29	Bldg Repairs from Storm Damage (Gross of W/Off-Line 5)			2014	55,760	1,394	40	1,394		3,601	29
30	Repaired/Replaced Roof, Gutters, Downspouts, Gazebo,										30
31	Garage, Exterior Walls, Siding										31
32	New Gazebo			2014	3,398	227	15	227		435	32
33	Replaced mixing valve & piping water heater			2014	1,850	123	15	123		195	33
34	Replace bathroom shower faucet, tub & drain			2015	1,268	85	15	85		92	34
35	Replace 1" line;rebuild ck valves sprinkler system			2015	1,450	56	15	56		56	35
36	Reroute Hot Water to Kitchen			2016	3,481	19	15	19		19	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	Allocation from Home Office		10,973			450	450		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)		$ 808,722	$ 21,653		$ 22,103	$ 450	$ 324,040	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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: 7/1/2015 Ending: 6/30/2016

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	$ 10,642	$ 1,160	$ 1,160	$	5-10 Yrs	$ 6,009	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,370				5-10 Yrs	15,370	73
74	Allocated from Home Office	21,506		1,687	1,687		16,676	74
75	TOTALS	$ 47,518	$ 1,160	$ 2,847	$ 1,687		$ 38,055	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2005 Dodge Caravan/Repairs	2005/2016	$ 20,006	$ 540	$ 540	$	5	$ 15,152	76
77										77
78										78
79	Allocated from Home Office			551		382	382			79
80	TOTALS			$ 20,557	$ 540	$ 922	$ 382		$ 15,152	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)	$ 903,454	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,353	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,872	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,519	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 377,247	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Misc Office Rental			56			5
6		Offset rental income			(56)			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 ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

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

16. Rental Amount for movable equipment: $ 2,718 Description: Allocated from Home Office - postage machine $88, copier $1,956, storage $674
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

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

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

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				2,188		2,188	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			$		$	$ 2,188		$ 2,188	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place **#** 0038240 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2016 **(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	$ 62,437	$ 62,437	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,185)	66,165	66,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)	116,480	116,480	8
9	Other(specify): Reserves/Deposits	78,318	78,318	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 329,111	$ 329,111	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,657	13
14	Buildings, at Historical Cost	56,500	808,722	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	27,577	68,075	16
17	Accumulated Depreciation (book methods)	(21,478)	(377,247)	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 Costs	5,792	5,792	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 88,391	$ 531,999	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 417,502	$ 861,110	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,810	$ 16,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,501	24,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,614	1,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,292	15,292	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	16,939	16,939	36
37	Deposits/Deferred Income	898	898	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 76,054	$ 76,054	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	774,137	774,137	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Bond Fund	74,199	74,199	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 848,336	$ 848,336	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 924,390	$ 924,390	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (506,888)	$ (63,280)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 417,502	$ 861,110	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (129,071)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (129,071)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(377,817)	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)**	$ (377,817)	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)**	$ (506,888)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 627,708	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 627,708	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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	34	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34	23
	D. Non-Operating Revenue		
24	Contributions	395	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 395	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	4,205	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,205	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 632,342	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	78,978	31
32	Health Care	177,407	32
33	General Administration	661,162	33
	B. Capital Expense		
34	Ownership	55,533	34
	C. Ancillary Expense		
35	Special Cost Centers	3,834	35
36	Provider Participation Fee	33,245	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,010,159	40
41	**Income before Income Taxes (line 30 minus line 40)****	(377,817)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (377,817)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 627,708	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 627,708	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? See Sch 19A If not, please attach a reconciliation.**

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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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	452	481	10,801	22.46	3
4	Licensed Practical Nurses	213	229	3,263	14.25	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,799	1,928	16,904	8.77	15
16	Dishwashers					16
17	Maintenance Workers	553	575	7,202	12.53	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	721	776	22,876	29.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	67	72	2,742	38.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2	2	34	17.00	28
29	Resident Services Coordinator	835	904	11,800	13.05	29
30	Habilitation Aides (DD Homes)	13,000	13,875	138,424	9.98	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	17,642	18,842	$ 214,046 *	$ 11.36	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	32	$ 1,717	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	897	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	21	1,259	L12, C3	45
46	Other(specify) Dental	1	92	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	54	$ 4,625		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 3,569
Amy Anderson	Administrator	0	10,038
Karla Rogers	Administrator	0	4,654
Joy Carlson	Administrator	0	4,615
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 22,876

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 552,742
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 552,742

C. Professional Services

Vendor/Payee	Type	Amount
Paychex	Payroll Service	$ 3,057
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 3,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,108
Unemployment Compensation Insurance	9,372
FICA Taxes	16,112
Employee Health Insurance	6,376
Employee Meals	3,003
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	213
Other Employee Benefits	130
Allocated from Home Office	10,901
TOTAL (agree to Schedule V, line 22, col.8)	$ 67,215

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 2)	70
Patient Background Checks	
Hiring Expense	738
Miscellaneous Dues & Fees	312
Allocated from Home Office	2,777
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,897

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	543
Seminar Expense	159
Allocated from Home Office	1,489
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,191

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,671** 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 fo
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 Departmen
during this cost report period. $ **33,245**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **3,003** 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 fo
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? **69**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **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
out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees