

		FOR BHF USE					

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**2015**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2015)**

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

<p><b>I. IDPH License ID Number:</b> <u>0038240</u></p> <p><b>Facility Name:</b> <u>Harris Place</u></p> <p><b>Address:</b> <u>209 Harris Road</u> <u>East Peoria</u> <u>61611</u>  Number City Zip Code</p> <p><b>County:</b> <u>Tazewell</u></p> <p><b>Telephone Number:</b> <u>(309) 698-9600</u> <b>Fax #</b> <u>(309) 698-9604</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/1992</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501 C (3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>630-361-2868</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2014</u> to <u>6/30/2015</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Jessica Rosales</u> (Title) <u>Chief Operating Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE  ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jessica Rosales</u> (Title) <u>Chief Operating Officer</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harris Place

# 0038240 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,311			4,311	13
14	TOTALS	4,311			4,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.82%

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

0 (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  Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES  NO

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

Date started 10/1/1992

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

YES  Date 03/08/1999 NO

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	17,430	2,658	1,813	21,901			21,901		1	
2	Food Purchase		21,152		21,152			21,152		2	
3	Housekeeping		3,386		3,386			3,386		3	
4	Laundry		1,391		1,391			1,391		4	
5	Heat and Other Utilities			15,517	15,517		42	15,559		5	
6	Maintenance	8,314	2,549	8,013	18,876		31	18,907		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	25,744	31,136	25,343	82,223		73	82,296		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			660	660			660		9	
10	Nursing and Medical Records	170,132	5,460	6,309	181,901			181,901		10	
10a	Therapy			980	980			980		10a	
11	Activities		1,876		1,876			1,876		11	
12	Social Services			1,106	1,106			1,106		12	
13	CNA Training									13	
14	Program Transportation			4,766	4,766			4,766		14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	170,132	7,336	13,821	191,289			191,289		16	
	<b>C. General Administration</b>										
17	Administrative	34,737		99,181	133,918		(99,181)	34,737		17	
18	Directors Fees						3,007	3,007		18	
19	Professional Services			3,592	3,592		8,972	12,564		19	
20	Dues, Fees, Subscriptions & Promotions			2,801	2,801		3,075	5,876		20	
21	Clerical & General Office Expenses	2,507	3,107	9,707	15,321		58,051	73,372		21	
22	Employee Benefits & Payroll Taxes			67,486	67,486		7,909	75,395		22	
23	Inservice Training & Education			352	352			352		23	
24	Travel and Seminar			975	975		1,286	2,261		24	
25	Other Admin. Staff Transportation			3,150	3,150		666	3,816		25	
26	Insurance-Prop.Liab.Malpractice			6,271	6,271		213	6,484		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	37,244	3,107	193,515	233,866		(16,002)	217,864		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	233,120	41,579	232,679	507,378		(15,929)	491,449		29	

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION 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 &amp; ID Number

Harris Place

#0038240

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			22,528	22,528	22,528	1,630	24,158				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,968	38,968	38,968	8,434	47,402				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles						2,523	2,523				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			61,496	61,496	61,496	12,587	74,083				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,598		2,598	2,598		2,598				39
40	Barber and Beauty Shops			66	66	66		66				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,523	36,523	36,523		36,523				42
43	Other (specify):* <b>Disallowed Costs</b>			9,264	9,264	9,264	(9,264)					43
44	<b>TOTAL Special Cost Centers</b>		2,598	45,853	48,451	48,451	(9,264)	39,187				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	233,120	44,177	340,028	617,325	617,325	(12,606)	604,719				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harris Place

# 0038240

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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				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	(9,264)	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 Pg 5A	(3,342)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (12,606)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (12,606)</b>		<b>37</b>

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Harris Place

ID# 0038240

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallowed HO expenses	\$ (1,960)	43	1
2	Offset rental income against expense	(1,382)	34	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	<b>Total</b>		(3,342)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harris Place# 0038240

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	42	0	0	0	0	0	0	0	0	0	42	5
6	Maintenance	0	31	0	0	0	0	0	0	0	0	0	31	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	73	0	0	0	0	0	0	0	0	0	73	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	(99,181)	0	0	0	0	0	0	0	0	0	(99,181)	17
18	Directors Fees	0	3,007	0	0	0	0	0	0	0	0	0	3,007	18
19	Professional Services	0	8,972	0	0	0	0	0	0	0	0	0	8,972	19
20	Fees, Subscriptions & Promotions	0	3,075	0	0	0	0	0	0	0	0	0	3,075	20
21	Clerical & General Office Expenses	0	58,051	0	0	0	0	0	0	0	0	0	58,051	21
22	Employee Benefits & Payroll Taxes	0	7,909	0	0	0	0	0	0	0	0	0	7,909	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,286	0	0	0	0	0	0	0	0	0	1,286	24
25	Other Admin. Staff Transportation	0	666	0	0	0	0	0	0	0	0	0	666	25
26	Insurance-Prop.Liab.Malpractice	0	213	0	0	0	0	0	0	0	0	0	213	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	(16,002)	0	0	0	0	0	0	0	0	0	(16,002)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	(15,929)	0	0	0	0	0	0	0	0	0	(15,929)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harris Place# 0038240

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	1,630	0	0	0	0	0	0	0	0	0	1,630	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	8,434	0	0	0	0	0	0	0	0	0	8,434	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,382)	0	1,382	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,523	0	0	0	0	0	0	0	0	2,523	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,382)</b>	<b>10,064</b>	<b>3,905</b>	<b>0</b>	<b>12,587</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(11,224)	0	1,960	0	0	0	0	0	0	0	0	(9,264)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(11,224)</b>	<b>0</b>	<b>1,960</b>	<b>0</b>	<b>(9,264)</b>	<b>44</b>							
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(12,606)</b>	<b>(5,865)</b>	<b>5,865</b>	<b>0</b>	<b>(12,606)</b>	<b>45</b>							

**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
<a href="#">Progressive Housing, Inc</a>	<u>100</u>	<a href="#">See Pg 6-Supp</a>		<a href="#">See Pg 6-Supp</a>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<a href="#">17 Administrative</a>	\$ <u>99,181</u>	<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	\$	\$ <u>(99,181)</u>	1
2	V	<a href="#">5 Utilities</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>42</u>	<u>42</u>	2
3	V	<a href="#">6 Maintenance</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>31</u>	<u>31</u>	3
4	V	<a href="#">18 Director Fees</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>3,007</u>	<u>3,007</u>	4
5	V	<a href="#">19 Professional Services</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>8,972</u>	<u>8,972</u>	5
6	V	<a href="#">20 Dues, Fees, Subs and Promotions</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>3,075</u>	<u>3,075</u>	6
7	V	<a href="#">21 Clerical and General Office</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>58,051</u>	<u>58,051</u>	7
8	V	<a href="#">22 Employee Benefits</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>7,909</u>	<u>7,909</u>	8
9	V	<a href="#">24 Travel and Seminar</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>1,286</u>	<u>1,286</u>	9
10	V	<a href="#">25 Auto Expense</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>666</u>	<u>666</u>	10
11	V	<a href="#">26 Insurance</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>213</u>	<u>213</u>	11
12	V	<a href="#">30 Depreciation</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>1,630</u>	<u>1,630</u>	12
13	V	<a href="#">32 Interest</a>		<a href="#">Progressive Housing, Inc.</a>	<u>100.00%</u>	<u>8,434</u>	<u>8,434</u>	13
14	<b>Total</b>		\$ <u>99,181</u>			\$ <u>93,316</u>	\$ * <u>(5,865)</u>	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rent		Progressive Housing, Inc.	100.00%	\$ 1,382	\$ 1,382	15
16	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	2,523	2,523	16
17	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,960	1,960	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	<b>Total</b>		\$			\$ 5,865	\$ * 5,865	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Harris Place

# 0038240

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

## 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			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates	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' COMPILATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,173	3Hrs/MTG	1.00	Dir. Fees	\$ 427	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,173	3Hrs/MTG	1.00	Dir. Fees	427	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	7,644	3Hrs/MTG	1.00	Dir. Fees	356	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,408	3Hrs/MTG	1.00	Dir. Fees	392	L18,C8	4
5	Cora Flota	Director	Board Member	None	9,173	3Hrs/MTG	1.00	Dir. Fees	427	L18,C8	5
6	Edward Copeland	Director	Board Member	None	9,173	3Hrs/MTG	1.00	Dir. Fees	427	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	5,351	3Hrs/MTG	1.00	Dir. Fees	249	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,705		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' COMPILATION REPORT

Harris Place  
0038240  
6/30/2015

SCHEDULE 7A

**BOARD OF DIRECTOR FEES**

*Progressive Housing, Inc.*

	<b>Cora Flota</b>	<b>Edward Childers</b>	<b>Edward Copeland</b>	<b>Orland Bauer</b>	<b>Robert Bauer</b>	<b>Shawn Jeffers</b>	<b>Eileen Mullin</b>	<b>Misc Exp</b>	<b>Total</b>
Sparta Terrace	366	366	366	366	305	335	213	263	2,579
Ellner Terrace	459	459	459	459	382	421	268	321	3,227
Taylorville Terrace	465	465	465	465	387	426	271	324	3,267
Aviston Terrace	397	397	397	397	331	364	232	282	2,799
Briarbrook Place	466	466	466	466	388	427	272	325	3,274
Harris Place	427	427	427	427	356	392	249	301	3,007
Joshua Manor	367	367	367	367	306	336	214	262	2,585
Terra Estates	442	442	442	442	368	405	258	310	3,107
Park Place	438	438	438	438	365	401	255	308	3,080
Western Gardens	236	236	236	236	197	216	138	162	1,658
Galaxy	273	273	273	273	227	250	159	187	1,914
Cardinal	204	204	204	204	170	187	119	144	1,433
Bill Goat Hill	249	249	249	249	207	228	145	172	1,747
Country Club Hill	214	214	214	214	178	196	125	147	1,503
Lee Street	267	267	267	267	222	245	156	180	1,870
Baker Street	205	205	205	205	171	188	120	141	1,442
182nd Street	228	228	228	228	190	209	133	156	1,603
Osage	189	189	189	189	158	173	110	131	1,329
Oakwood	220	220	220	220	183	202	128	151	1,543
Blair	305	305	305	305	254	280	178	209	2,142
Lowell	267	267	267	267	222	245	156	182	1,872
Marquette	247	247	247	247	206	226	144	169	1,732
Cherry	234	234	234	234	195	215	137	159	1,643
Luella	220	220	220	220	183	202	128	155	1,547
Olivia	310	310	310	310	258	284	181	209	2,173
Huron	228	228	228	228	190	209	133	156	1,603
Wilshire	269	269	269	269	224	246	157	184	1,886

Constance	236	236	236	236	197	216	138	162	1,658
175th Place	270	270	270	270	225	247	157	184	1,892
Sauganash	-	-	-	-	-	-	-	10	10
Steger	510	510	510	510	425	467	297	337	3,565
Waltonville	194	194	194	194	162	178	113	129	1,357
Mt. Vernon	200	200	200	200	166	183	116	135	1,400
<b>Total BOD Expense</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>9,600</b>	<b>8,000</b>	<b>8,800</b>	<b>5,600</b>	<b>6,647</b>	<b>67,447</b>

Facility Name & ID Number Harris Place

# 0038240

Report Period Beginning:

7/1/2014

Ending:

7/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Budgeted Rev/Dir Cost	33	939		560,438	\$ 42	1
2	6	Maintenance	Budgeted Rev/Dir Cost	33	701		560,438	31	2
3	18	Director Fees	Budgeted Rev/Dir Cost	33	67,447		560,438	3,007	3
4	19	Professional Services	Budgeted Rev/Dir Cost	33	204,232		560,438	8,972	4
5	20	Dues, Fees, Subs and Promotions	Budgeted Rev/Dir Cost	33	74,328		560,438	3,075	5
6	21	Clerical and General Office	Budgeted Rev/Dir Cost	33	1,291,500	1,101,919	560,438	58,051	6
7	22	Employee Benefits	Budgeted Rev/Dir Cost	33	178,040		560,438	7,909	7
8	24	Travel and Seminar	Budgeted Rev/Dir Cost	33	27,459		560,438	1,286	8
9	25	Auto Expense	Budgeted Rev/Dir Cost	33	14,968		560,438	666	9
10	26	Insurance	Budgeted Rev/Dir Cost	33	8,530		560,438	213	10
11	30	Depreciation	Budgeted Rev/Dir Cost	33	36,018		560,438	1,630	11
12	32	Interest	Budgeted Rev/Dir Cost	33	238,933		560,438	8,434	12
13	34	Rent	Budgeted Rev/Dir Cost	33	31,050		560,438	1,382	13
14	35	Equipment Rental	Budgeted Rev/Dir Cost	33	40,919		560,438	2,523	14
15	43	Non-Allowable Expenses	Budgeted Rev/Dir Cost	33	281,423		560,438	1,960	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,496,487	\$ 1,101,919		\$ 99,181	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	<b>Il Health Facility Auth Bond</b>		X	<b>Facility Purchase</b>	<b>Varies</b>	<b>03/09/06</b>	\$ <b>945,517</b>	\$ <b>727,672</b>	<b>08/15/26</b>	<b>6.7500</b>	\$ <b>37,606</b>	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6	<b>Amortization</b>										<b>1,362</b>	6					
7	<b>Allocation from Home Office-Interest</b>										<b>10,480</b>	7					
8	<b>Allocation from Home Office-Amortization</b>										<b>550</b>	8					
9	<b>TOTAL Facility Related</b>						\$ <b>945,517</b>	\$ <b>727,672</b>			\$ <b>49,998</b>	9					
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12									<b>Interest Income Offset</b>		<b>(2,596)</b>	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ <b>(2,596)</b>	14					
15	<b>TOTALS (line 9+line14)</b>						\$ <b>945,517</b>	\$ <b>727,672</b>			\$ <b>47,402</b>	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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



## 2014 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 2014 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 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
<b>TOTALS</b>			\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

**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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.**

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	<u>1</u>
2	<u>Allocated from Home Office</u>			<u>4,910</u>	<u>2</u>
3	<b>TOTALS</b>	<b>47,250</b>		<b>\$ 24,910</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Harris Place

# 0038240

Report Period Beginning:

7/1/2014

Ending:

6/30/2015

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1999	1991	\$ 730,000	\$ 18,250	40	\$ 18,250	\$	\$ 298,114	4
5			2013	(39,426)	(986)	40	(986)		(15,524)	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Carpeting		1999	2,183		15			2,183	9
10	Drive Repaving		2004	1,498	100	15	100		1,091	10
11	Bathroom Carpet		2006	945	63	15	63		572	11
12	Carpeting (Replaced-See Line 28 below)		2006			15				12
13	Batheoom Toilets		2006	1,026	68	15	68		604	13
14	Bathroom Remodel		2006	5,100	340	15	340		2,947	14
15	Bathroom Remodel		2006	3,043	203	15	203		1,742	15
16	Bathroom Remodel		2007	3,355	224	15	224		1,884	16
17	Gazebo		2007	1,896	126	15	126		956	17
18	Concrete Sidewalk		2009	2,255	150	15	150		938	18
19	Repair the Water Line to Showers		2009	2,562	171	15	171		951	19
20	Bedroom Carpeting		2010	565	38	15	38		193	20
21	Bathroom Remodel		2010	430	29	15	29		147	21
22	Exterior Door for Facility		2010	344	23	15	23		123	22
23	Replace air compressor in sprinkler system		2011	1,250	83	15	83		339	23
24	100 Gallon Hot Water Heater		2011	5,605	374	15	374		1,776	24
25	Furnace Inducer		2012	742	49	15	49		174	25
26	Flooring-Women's Bathroom		2013	516	34	15	34		66	26
27	Replace Dry System Piping with Galvanized Piping		2014	4,903	327	15	327		490	27
28	Carpeting - Living Room, Activity Room and Small Office		2014	1,750	117	15	117		127	28
29	Bldg Repairs from Storm Damage (Gross of W/Off-Line 5)		2014	55,760	1,394	40	1,394		2,207	29
30	Repaired/Replaced Roof, Gutters, Downspouts, Gazebo,									30
31	Garage, Exterior Walls, Siding									31
32	New Gazebo		2014	3,398	208	15	208		208	32
33	Replaced mixing valve & piping water heater		2014	1,850	72	15	72		72	33
34	Replace bathroom shower faucet, tub & drain		2015	1,268	7	15	7		7	34
35	Allocation from Home Office			17,600			207	207	1,055	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harris Place

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	810,418	\$	21,464	\$	21,671	\$	207	\$	303,442	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 10,642	\$ 1,064	\$ 1,064	\$	5-10Yrs	\$ 4,849	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	15,370				5-10Yrs	15,370	73
74	Allocated from Home Office	15,378		1,152	1,152		10,805	74
75	TOTALS	\$ 41,390	\$ 1,064	\$ 2,216	\$ 1,152		\$ 31,024	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	2005	\$ 14,612	\$	\$	\$	5	\$ 14,612	76
77										77
78										78
79	Allocated from Home Office			6,422		271	271		5,637	79
80	TOTALS			\$ 21,034	\$	\$ 271	\$ 271		\$ 20,249	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)	\$ 897,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,158	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,630	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 354,715	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		Allocated from Home Office			1,382			5
6		Offset rental income			(1,382)			6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 2,523 Description: Allocated from Home Office - postage machine \$70, copier \$2033, storage \$420

(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' COMPILATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				2,598		2,598	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	<b>TOTAL</b>			\$		\$	2,598		\$ 2,598	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' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 33,069	\$ 33,069	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>16,961</u> )	31,290	31,290	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,242	2,242	7
8	Accounts Receivable (owners or related parties)	(23,686)	(23,686)	8
9	Other(specify): <u>Reserves/Deposits</u>	82,605	82,605	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 125,520	\$ 125,520	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	24,910	13
14	Buildings, at Historical Cost	792,818	810,418	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	40,624	62,424	16
17	Accumulated Depreciation (book methods)	(337,218)	(354,715)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan costs</u> )	5,364	5,364	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 521,588	\$ 548,401	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 647,108	\$ 673,921	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 9,459	\$ 9,459	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,260	16,260	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,863	2,863	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,566	11,566	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	7,390	7,390	36
37	<u>Deposits/Deferred Income</u>	969	969	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 48,507	\$ 48,507	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	727,672	727,672	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 727,672	\$ 727,672	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 776,179	\$ 776,179	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (129,071)	\$ (102,258)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 647,108	\$ 673,921	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (70,788)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (70,788)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(58,283)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (58,283)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (129,071)	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harris Place# 0038240Report Period Beginning: 7/1/2014Ending: 6/30/2015

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 554,091	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 554,091	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	61	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 61	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,535	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,535	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rental Income</u>	2,355	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,355	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 559,042	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	82,223	31
32	Health Care	191,289	32
33	General Administration	233,866	33
<b>B. Capital Expense</b>			
34	Ownership	61,496	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	11,928	35
36	Provider Participation Fee	36,523	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 617,325	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(58,283)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (58,283)	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 554,091	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 554,091	49

\* 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Harris Place**  
**0038240**  
**6/30/2015**

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:

7/1/2014

Ending:

6/30/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	53	1,418	22.51	3
4	Licensed Practical Nurses	267	4,680	16.71	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	1,893	17,430	8.64	15
16	Dishwashers				16
17	Maintenance Workers	706	8,314	11.30	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	1,188	34,737	28.10	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	63	2,507	38.57	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,562	24,534	15.71	29
30	Habilitation Aides (DD Homes)	14,385	139,500	9.27	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	20,117	21,009	\$ 233,120 *	\$ 11.10 34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	34	\$ 1,813	L1, C3 35
36	Medical Director	Monthly	660	L9, C3 36
37	Medical Records Consultant			37
38	Nurse Consultant	217	5,498	L10, C3 38
39	Pharmacist Consultant	Monthly	811	L10, C3 39
40	Physical Therapy Consultant	3	270	L10a, C3 40
41	Occupational Therapy Consultant	3	270	L10a, C3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	11	440	L10a, C3 43
44	Activity Consultant			44
45	Social Service Consultant	18	1,106	L12, C3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	286	\$ 10,868	49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Harris Place

# 0038240

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

## 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 political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,302 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,523  
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' COMPILATION REPORT

- (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. \$ 3,286 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? 56
- 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 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.