



Facility Name & ID Number Harris Place

# 0038240 Report Period Beginning: 7/1/16 Ending: 6/30/17

**III. STATISTICAL DATA**

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

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

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,473			4,473	13
14	TOTALS	4,473			4,473	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.59%**

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve 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: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/16 Ending: 6/30/17

**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	19,870	743	1,565	22,178		22,178		22,178		1
2	Food Purchase		31,677		31,677		31,677		31,677		2
3	Housekeeping		1,863		1,863		1,863	50	1,913		3
4	Laundry		1,230		1,230		1,230		1,230		4
5	Heat and Other Utilities			17,803	17,803		17,803		17,803		5
6	Maintenance	10,587	2,339	7,810	20,736		20,736	1,780	22,516		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	30,457	37,852	27,178	95,487		95,487	1,830	97,317		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	179,662	4,582	9,203	193,447		193,447		193,447		10
10a	Therapy										10a
11	Activities		574	62	636		636		636		11
12	Social Services			1,243	1,243		1,243		1,243		12
13	CNA Training										13
14	Program Transportation			3,962	3,962		3,962		3,962		14
15	Other (specify):*			170	170		170		170		15
16	<b>TOTAL Health Care and Programs</b>	179,662	5,156	15,300	200,118		200,118		200,118		16
	<b>C. General Administration</b>										
17	Administrative	39,098		134,161	173,259		173,259	(134,161)	39,098		17
18	Directors Fees							4,284	4,284		18
19	Professional Services			4,268	4,268		4,268	7,043	11,311		19
20	Dues, Fees, Subscriptions & Promotions			742	742		742	1,716	2,458		20
21	Clerical & General Office Expenses	3,906	1,491	9,566	14,963		14,963	66,154	81,117		21
22	Employee Benefits & Payroll Taxes			78,177	78,177		78,177	11,027	89,204		22
23	Inservice Training & Education			1,187	1,187		1,187		1,187		23
24	Travel and Seminar			270	270		270	1,998	2,268		24
25	Other Admin. Staff Transportation			2,142	2,142		2,142	1,075	3,217		25
26	Insurance-Prop.Liab.Malpractice			8,549	8,549		8,549	563	9,112		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	43,004	1,491	239,062	283,557		283,557	(40,301)	243,256		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	253,123	44,499	281,540	579,162		579,162	(38,471)	540,691		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 &amp; ID Number

Harris Place

#0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

## 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			4,144	4,144		4,144	21,797	25,941			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,049	30,049		30,049	10,732	40,781			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			400	400		400	(400)				34
35	Rent-Equipment & Vehicles							2,588	2,588			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			34,593	34,593		34,593	34,717	69,310			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,074		2,074		2,074		2,074			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,663	37,663		37,663		37,663			42
43	Other (specify):* <b>Disallowed Costs</b>			14,000	14,000		14,000	(14,000)				43
44	<b>TOTAL Special Cost Centers</b>		2,074	51,663	53,737		53,737	(14,000)	39,737			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	253,123	46,573	367,796	667,492		667,492	(17,754)	649,738			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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,105	30		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	(14,000)	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	(23,859)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (17,754)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (17,754)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

Harris Place

ID# 0038240

Report Period Beginning: 7/1/16

Ending: 6/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (25,221)	43	1
2	Capitalized Repairs under \$2,500	1,762	6	2
3	Offset Rent Income Against Expense	(400)	34	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>	(23,859)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harris Place# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
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	50	0	0	0	0	0	0	0	0	0	50	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,762	18	0	0	0	0	0	0	0	0	0	1,780	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,762</b>	<b>68</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,830</b>	<b>8</b>
	<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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(134,161)	0	0	0	0	0	0	0	0	(134,161)	17
18	Directors Fees	0	4,284	0	0	0	0	0	0	0	0	0	4,284	18
19	Professional Services	0	7,043	0	0	0	0	0	0	0	0	0	7,043	19
20	Fees, Subscriptions & Promotions	0	1,716	0	0	0	0	0	0	0	0	0	1,716	20
21	Clerical & General Office Expenses	0	66,154	0	0	0	0	0	0	0	0	0	66,154	21
22	Employee Benefits & Payroll Taxes	0	11,027	0	0	0	0	0	0	0	0	0	11,027	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,998	0	0	0	0	0	0	0	0	0	1,998	24
25	Other Admin. Staff Transportation	0	1,075	0	0	0	0	0	0	0	0	0	1,075	25
26	Insurance-Prop.Liab.Malpractice	0	563	0	0	0	0	0	0	0	0	0	563	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>93,860</b>	<b>(134,161)</b>	<b>0</b>	<b>(40,301)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>1,762</b>	<b>93,928</b>	<b>(134,161)</b>	<b>0</b>	<b>(38,471)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harris Place# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	20,105	1,692	0	0	0	0	0	0	0	0	0	21,797	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	10,732	0	0	0	0	0	0	0	0	0	10,732	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(400)	0	0	0	0	0	0	0	0	0	0	(400)	34
35	Rent-Equipment & Vehicles	0	2,588	0	0	0	0	0	0	0	0	0	2,588	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>19,705</b>	<b>15,012</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34,717</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):*	(39,221)	0	25,221	0	0	0	0	0	0	0	0	(14,000)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(39,221)</b>	<b>0</b>	<b>25,221</b>	<b>0</b>	<b>(14,000)</b>	<b>44</b>							
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(17,754)</b>	<b>108,940</b>	<b>(108,940)</b>	<b>0</b>	<b>(17,754)</b>	<b>45</b>							

Facility Name & ID Number

Harris Place

# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	3 Housekeeping	\$	Progressive Housing, Inc.	100.00%	\$ 50	\$	50	1
2	V	6 Maintenance		Progressive Housing, Inc.	100.00%	18		18	2
3	V	18 Director Fees		Progressive Housing, Inc.	100.00%	4,284		4,284	3
4	V	19 Professional Services		Progressive Housing, Inc.	100.00%	7,043		7,043	4
5	V	20 Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	1,716		1,716	5
6	V	21 Clerical and General Office	36	Progressive Housing, Inc.	100.00%	66,190		66,154	6
7	V	22 Employee Benefits		Progressive Housing, Inc.	100.00%	11,027		11,027	7
8	V	24 Travel and Seminar		Progressive Housing, Inc.	100.00%	1,998		1,998	8
9	V	25 Auto Expense		Progressive Housing, Inc.	100.00%	1,075		1,075	9
10	V	26 Insurance		Progressive Housing, Inc.	100.00%	563		563	10
11	V	30 Depreciation		Progressive Housing, Inc.	100.00%	1,692		1,692	11
12	V	32 Interest	2,662	Progressive Housing, Inc.	100.00%	13,394		10,732	12
13	V	35 Equipment Rental		Progressive Housing, Inc.	100.00%	2,588		2,588	13
14	Total		\$ 2,698			\$ 111,638	\$ *	108,940	14

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

SEE ACCOUNTANTS' PREPARATION 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	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	\$ 25,221	\$ 25,221	15
16	V	17 Administrative	134,161	Progressive Housing, Inc.	100.00%		(134,161)	16
17	V							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		\$ 134,161			\$ 25,221	\$ * (108,940)	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace -closed	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

Facility Name &amp; ID Number

Harris Place

# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

## 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	8,917	3Hrs/MTG	1.00	Dir. Fees	\$ 564	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,948		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

Facility Name & ID Number Harris Place

# 0038240

Report Period Beginning:

7/1/16

Ending: 6/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Bed Capacity/Specific Alloc.	263	29	968	16	\$ 50	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	263	29	303	16	18	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	263	29	72,251	16	4,284	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	263	29	117,723	16	7,043	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	263	29	29,301	16	1,716	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	263	29	1,117,820	16	66,190	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	263	29	186,014	16	11,027	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	263	29	24,967	16	1,998	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	263	29	18,123	16	1,075	9
10	26	Insurance	Bed Capacity/Specific Alloc.	263	29	9,561	16	563	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	263	29	28,653	16	1,692	11
12	32	Interest	Bed Capacity/Specific Alloc.	263	29	214,829	16	13,394	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	263	29	43,864	16	2,588	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	263	29	218,508	16	25,221	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,082,885	\$ 949,691	\$ 136,859	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Harris Place

# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

**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**					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	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 945,517	\$ 774,137	08/15/26	6.7500	\$ 28,472	1				
2												2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 945,517	\$ 774,137			\$ 28,472	9				
<b>B. Non-Facility Related*</b>																
10								Amortization			1,577	10				
11								Home Office Allocation			13,394	11				
12								Interest Income Offset-HO			(2,662)	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 12,309	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 945,517	\$ 774,137			\$ 40,781	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' PREPARATION REPORT

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

(See instructions.)



# 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harris Place COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0038240

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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:

7/1/16

Ending:

6/30/17

**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:**

A. Land.

	1	2	3	4	
	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>6,834</u>	<u>2</u>
3	<b>TOTALS</b>	<b>47,250</b>		<b>\$ 26,834</b>	<b>3</b>

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Harris Place

# 0038240

Report Period Beginning:

7/1/16

Ending:

6/30/17

**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 *	\$	40	\$ 18,250	\$ 18,250	\$ 334,614	4
5			2013	(39,426)		40	(986)	(986)	(17,496)	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		15	100	100	1,291	10
11	Bathroom Carpet		2006	945		15	63	63	698	11
12	Carpeting (Replaced-See Line 28 below)		2006			15				12
13	Batheoom Toilets		2006	1,026		15	68	68	740	13
14	Bathroom Remodel		2006	5,100		15	340	340	3,627	14
15	Bathroom Remodel		2006	3,043		15	203	203	2,148	15
16	Bathroom Remodel		2007	3,355		15	224	224	2,332	16
17	Gazebo		2007	1,896		15	126	126	1,208	17
18	Concrete Sidewalk		2009	2,255		15	150	150	1,238	18
19	Repair the Water Line to Showers		2009	2,562		15	171	171	1,293	19
20	Bedroom Carpeting		2010	565		15	38	38	269	20
21	Bathroom Remodel		2010	430		15	29	29	205	21
22	Exterior Door for Facility		2010	344		15	23	23	169	22
23	Replace air compressor in sprinkler system		2011	1,250		15	83	83	471	23
24	100 Gallon Hot Water Heater		2011	5,605		15	374	374	2,524	24
25	Furnace Inducer		2012	742		15	49	49	272	25
26	Flooring-Women's Bathroom		2013	516		15	34	34	134	26
27	Replace Dry System Piping with Galvanized Piping		2014	4,903		15	327	327	1,144	27
28	Carpeting - Living Room, Activity Room and Small Office		2014	1,750		15	117	117	361	28
29	Bldg Repairs from Storm Damage (Gross of W/Off-Line 5)		2014	55,760		40	1,394	1,394	4,995	29
30	Repaired/Replaced Roof, Gutters, Downspouts, Gazebo,									30
31	Garage, Exterior Walls, Siding									31
32	New Gazebo		2014	3,398		15	227	227	662	32
33	Replaced mixing valve & piping water heater		2014	1,850		15	123	123	318	33
34	Replace bathroom shower faucet, tub & drain		2015	1,268		15	85	85	177	34
35	Replace 1" line;rebuild ck valves sprinkler system		2015	1,450		15	97	97	153	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' PREPARATION REPORT

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Reroute Hot Water to Kitchen	2016	\$ 3,481	\$	15	\$ 232	\$ 232	\$ 251	37
38	Replace Hot Water Heater	2017	6,453		15	179	179	179	38
39	Replace AC Unit - Back end of Building	2017	4,618		15	26	26	26	39
40									40
41									41
42									42
43	Financial Statement Depreciation			4,144			(4,144)		43
44									44
45									45
46									46
47	Allocated from Home Office		11,751			320	320		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)		\$ 820,571	\$ 4,144		\$ 22,466	\$ 18,322	\$ 346,186	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:

7/1/16

Ending:

6/30/17

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	\$	\$ 938	\$ 938	5-10 Yrs	\$ 7,046	71
72	Current Year Purchases	579		58	58	10 Yrs	58	72
73	Fully Depreciated Assets	15,370				5-10 Yrs	15,370	73
74	Allocated from Home Office	22,205		1,222	1,222		18,863	74
75	TOTALS	\$ 48,796	\$	\$ 2,218	\$ 2,218		\$ 41,337	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	\$	\$ 1,079	\$ 1,079	5	\$ 16,231	76
77	Resident Transportation	Capitalized Repairs	2017	1,698		28	28	5	28	77
78										78
79	Allocated from Home Office			851		150	150			79
80	TOTALS			\$ 22,555	\$	\$ 1,257	\$ 1,257		\$ 16,259	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)	\$ 918,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,941	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,797	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 403,782	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

**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 Rent				400			5
6	Offset Rent Income				(400)			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 2,588 Description: Allocated from Home Office - postage machine \$92, copier \$1,701, storage \$795

(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	<u>N/A</u>		\$	\$	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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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' PREPARATION REPORT**

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

	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 prescripts				2,074		2,074	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>			\$		\$	2,074		\$ 2,074	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/17

(last day of reporting year)

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	\$ 41,139	\$ 41,139	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,806 )	93,756	93,756	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,984	5,984	7
8	Accounts Receivable (owners or related parties)	63,353	63,353	8
9	Other(specify): Reserves/Deposits	80,250	80,250	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 284,482	\$ 284,482	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,834	13
14	Buildings, at Historical Cost	69,333	820,571	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	29,854	71,351	16
17	Accumulated Depreciation (book methods)	(25,622)	(403,782)	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	4,223	4,223	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 97,788	\$ 519,197	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 382,270	\$ 803,679	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 13,341	\$ 13,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,255	25,255	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,375	1,375	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	51,579	51,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Expenses	30,689	30,689	36
37	Deferred Income	459	459	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 122,698	\$ 122,698	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	774,137	774,137	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Due to Bond Fund	74,199	74,199	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 848,336	\$ 848,336	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 971,034	\$ 971,034	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (588,764)	\$ (167,355)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 382,270	\$ 803,679	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(506,888)</b>	<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>	\$ <b>(506,888)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(81,876)	<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>	\$ <b>(81,876)</b>	<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>	\$ <b>(588,764)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 583,567	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 583,567	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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	59	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 59	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rental Income</u>	1,990	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,990	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 585,616	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	95,487	31
32	Health Care	200,118	32
33	General Administration	283,557	33
<b>B. Capital Expense</b>			
34	Ownership	34,593	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	16,074	35
36	Provider Participation Fee	37,663	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 667,492	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(81,876)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (81,876)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 583,567	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>	\$ 583,567	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 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.

**Harris Place**  
**0038240**  
**6/30/17**

**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:

7/1/16

Ending:

6/30/17

**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	510	12,107	22.67	3
4	Licensed Practical Nurses				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	1,807	19,870	10.34	15
16	Dishwashers				16
17	Maintenance Workers	957	10,587	10.03	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	1,236	39,098	30.10	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	115	3,906	30.05	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	2,056	29,051	13.75	29
30	Habilitation Aides (DD Homes)	12,066	138,504	10.63	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,747	253,123 *	12.60	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	29	\$ 1,565	L1, C3	35
36	Medical Director	Monthly	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	7,420	L10, C3	38
39	Pharmacist Consultant	Monthly	1,033	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	1	62	L11, C3	44
45	Social Service Consultant	23	1,243	L12, C3	45
46	Other(specify) <u>Dental</u>	Monthly	750	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	53	\$ 12,733		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' PREPARATION REPORT

Facility Name & ID Number Harris Place

# 0038240

Report Period Beginning: 7/1/16

Ending: 6/30/17

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Christina Durbin	Administrator	0	\$ 9,473	Workers' Compensation Insurance	\$ 20,047	IDPH License Fee	\$		
Laura Depauw	Administrator	0	15,169	Unemployment Compensation Insurance	8,740	Advertising: Employee Recruitment			
Joy Carlson	Administrator	0	14,456	FICA Taxes	18,576	Health Care Worker Background Check			
				Employee Health Insurance	25,390	(Indicate # of checks performed )			
				Employee Meals	4,783	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Hiring Expense	212		
				Life Insurance	229	Miscellaneous Dues & Fees	530		
				Other Employee Benefits	412				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 39,098						
B. Administrative - Other				Allocated from Home Office			11,027		
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 89,204		
Allocated from Progressive Housing, Inc.			\$ 134,161						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 134,161	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
(Attach a copy of any management service agreement)				G. Schedule of Travel and Seminar**					
C. Professional Services				Description			Amount		
Vendor/Payee	Type		Amount	Description	Line #	Amount			
Paychex	Payroll Service		\$ 1,891	N/A			Out-of-State Travel	\$	
Paycor	Payroll Service		1,762						
Benetrac	Payroll Service		275				In-State Travel	52	
MyStaffingPro	Payroll Service		107						
Sheakley Paysystems	Payroll Service		233				Seminar Expense	618	
							Allocated from Home Office	1,598	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,268
(For legal fee disclosure, see page 39 of instructions)			\$ 4,268						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

