FOR BHF USE

LL1

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

2021
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2021)

I. IDPH License ID Number: 0038240

Facility Name: Harris Place

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

County: Tazewell

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/20 to 6/30/21 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Mark Heptinstall
(Title) Chief Financial Officer

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,245			4,245	13
14	TOTALS	4,245			4,245	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.69%

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 [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/21 Fiscal Year: 6/30/21

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	26,332	1,004	2,041	29,377		29,377		29,377			1
2	Food Purchase		28,074		28,074		28,074		28,074			2
3	Housekeeping		5,194		5,194		5,194		5,194			3
4	Laundry		805		805		805		805			4
5	Heat and Other Utilities			19,658	19,658		19,658		19,658			5
6	Maintenance	15,628	6,296	15,046	36,970		36,970	587	37,557			6
7	Other (specify):*											7
8	**TOTAL General Services**	41,960	41,373	36,745	120,078		120,078	587	120,665			8
	B. Health Care and Programs											
9	Medical Director			880	880		880		880			9
10	Nursing and Medical Records	221,234	7,188	477	228,899		228,899		228,899			10
10a	Therapy											10a
11	Activities		603	230	833		833		833			11
12	Social Services			510	510		510		510			12
13	CNA Training	18,713			18,713		18,713		18,713			13
14	Program Transportation			5,781	5,781		5,781		5,781			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	239,947	7,791	7,878	255,616		255,616		255,616			16
	C. General Administration											
17	Administrative	50,995		122,078	173,073		173,073	(122,078)	50,995			17
18	Directors Fees							5,129	5,129			18
19	Professional Services			14,048	14,048		14,048	6,807	20,855			19
20	Dues, Fees, Subscriptions & Promotions			6,538	6,538		6,538	6,825	13,363			20
21	Clerical & General Office Expenses	9,469	2,670	13,331	25,470		25,470	80,858	106,328			21
22	Employee Benefits & Payroll Taxes			84,186	84,186		84,186	11,700	95,886			22
23	Inservice Training & Education			2,711	2,711		2,711		2,711			23
24	Travel and Seminar			562	562		562	2,900	3,462			24
25	Other Admin. Staff Transportation			768	768		768	43	811			25
26	Insurance-Prop.Liab.Malpractice			10,895	10,895		10,895	484	11,379			26
27	Other (specify):*											27
28	**TOTAL General Administration**	60,464	2,670	255,117	318,251		318,251	(7,332)	310,919			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	342,371	51,834	299,740	693,945		693,945	(6,745)	687,200			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Harris Place #0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			18,940	18,940		18,940	16,193	35,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,577	2,577		2,577	(421)	2,156			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,679	2,679			35
36	Other (specify):*											36
37	**TOTAL Ownership**			21,517	21,517		21,517	18,451	39,968			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,860		1,860		1,860		1,860			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,351	44,351		44,351		44,351			42
43	Other (specify):* **Disallowed Costs**											43
44	**TOTAL Special Cost Centers**		1,860	44,351	46,211		46,211		46,211			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	342,371	53,694	365,608	761,673		761,673	11,706	773,379			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,966	30		9
10	Interest and Other Investment Income	(421)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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				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	(1,839)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 11,706		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 11,706		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Harris Place

ID# 0038240

Report Period Beginning: 7/1/20

Ending: 6/30/21

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallowed HO Costs	$ (1,394)	43	1
2	Rental Income Offset	(445)	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
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,839)		49

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	Progressive Housing, Inc.	100.00%	$ 587	$ 587	1
2	V	18	Director Fees		Progressive Housing, Inc.	100.00%	5,129	5,129	2
3	V	19	Professional Services		Progressive Housing, Inc.	100.00%	6,807	6,807	3
4	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	6,825	6,825	4
5	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	80,858	80,858	5
6	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	11,700	11,700	6
7	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	2,900	2,900	7
8	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	43	43	8
9	V	26	Insurance		Progressive Housing, Inc.	100.00%	484	484	9
10	V	30	Depreciation		Progressive Housing, Inc.	100.00%	2,227	2,227	10
11	V	34	Rent		Progressive Housing, Inc.	100.00%	445	445	11
12	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	2,679	2,679	12
13	V	43	Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	1,394	1,394	13
14	Total			$			$ 122,078	$ * 122,078	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Administrative	$ 122,078	Progressive Housing, Inc.	100.00%	$	$ (122,078)	15
16	V								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			$ 122,078			$ 0	$ * (122,078)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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			Aviston Terrace	Aviston	Perfection			3
4			Briarbrook	East Peoria	Cleaning	Olympia Fields	Housekeeping	4
5			Joshua Manor	Hoyleton				5
6			Park Place	Pana				6
7			Cardinal	Woodlawn				7
8			Western Gardens	MT. Vernon				8
9			Galaxy	Woodlawn				9
10			Bill Goat Hill	MT. Vernon				10
11			Country Club Hill	Country Club Hills				11
12			Lee street	Country Club Hills				12
13			Baker Street	Country Club Hills				13
14			182nd Street	Country Club Hills				14
15			Osage	Park Forest				15
16			Oakwood	Park Forest				16
17			Blair	Park Forest				17
18			Lowell	Hazelcrest				18
19			Marquette	Park Forest				19
20			Luella	Sauk Village				20
21			Huron	Park Forest				21
22			Wilshire	Park Forest				22
23			175th Place	Country Club Hills				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	8,958	3Hrs/MTG	1.00	Dir. Fees	$ 642	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	3
4	Hal Brown	Director	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	6
7	Eileen Mullin	Director	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	7
8	Julie Lilie	Director	Board Member	None	8,959	3Hrs/MTG	1.00	Dir. Fees	641	L18,C8	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,129		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: 7/1/20 Ending: 6/30/21

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Bed Capacity/Specific Alloc.	228	25	$ 11,256	$	16	$ 587	1
2	18	Director Fees	Bed Capacity/Specific Alloc.	228	25	76,800		16	5,129	2
3	19	Professional Services	Bed Capacity/Specific Alloc.	228	25	106,861		16	6,807	3
4	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	228	25	99,735		16	6,825	4
5	21	Clerical and General Office	Bed Capacity/Specific Alloc.	228	25	1,215,568	954,963	16	80,858	5
6	22	Employee Benefits	Bed Capacity/Specific Alloc.	228	25	178,533		16	11,700	6
7	24	Travel and Seminar	Bed Capacity/Specific Alloc.	228	25	38,601		16	2,900	7
8	25	Auto Expense	Bed Capacity/Specific Alloc.	228	25	634		16	43	8
9	26	Insurance	Bed Capacity/Specific Alloc.	228	25	7,288		16	484	9
10	30	Depreciation	Bed Capacity/Specific Alloc.	228	25	32,892		16	2,227	10
11	34	Rent	Bed Capacity/Specific Alloc.	228	25	6,704		16	445	11
12	35	Equipment Rental	Bed Capacity/Specific Alloc.	228	25	51,586		16	2,679	12
13	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	228	25	15,681		16	1,394	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,139	$ 954,963		$ 122,078	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Enterprise		X	Vehicle	$605.11	2/2019	29,210	16,142	1/2024	0.0588	2,577	6
7	Peoples Bank		X	PPP Loan		4/14/20	116,788					7
8												8
9	TOTAL Facility Related				$605.11		$ 145,998	$ 16,142			$ 2,577	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(421)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (421)	14
15	TOTALS (line 9+line14)						$ 145,998	$ 16,142			$ 2,156	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2020 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2021 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2016	N/A	8
2017	N/A	9
2018	N/A	10
2019	N/A	11
2020	N/A	12

N/A - Not for profit entity

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2020	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2020 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 2020 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 2020.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2020 tax bills which were listed in Section A to this statement. Be sure to use the 2020 tax bill which is normally paid during 2021.

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: 7/1/20 Ending: 6/30/21

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	47,250	1999	$ 20,000	1
2	Allocated from Home Office			7,886	2
3	TOTALS	47,250		$ 27,886	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	$ 730,000 *	$	40	$ 18,250	$ 18,250	$ 407,614	4
5				2013	(39,426)		40	(986)	(986)	(21,440)	5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			1999	2,183		15			2,183	9
10	Drive Repaving			2004	1,498		15			1,498	10
11	Bathroom Carpet			2006	945		15	58	58	945	11
12	Carpeting (Replaced-See Line 28 below)			2006			15				12
13	Batheoom Toilets			2006	1,026		15	68	68	1,012	13
14	Bathroom Remodel			2006	5,100		15	340	340	4,987	14
15	Bathroom Remodel			2006	3,043		15	203	203	2,960	15
16	Bathroom Remodel			2007	3,355		15	224	224	3,228	16
17	Gazebo			2007	1,896		15	126	126	1,712	17
18	Concrete Sidewalk			2009	2,255		15	150	150	1,838	18
19	Repair the Water Line to Showers			2009	2,562		15	171	171	1,977	19
20	Bedroom Carpeting			2010	565		15	38	38	421	20
21	Bathroom Remodel			2010	430		15	29	29	321	21
22	Exterior Door for Facility			2010	344		15	23	23	261	22
23	Replace air compressor in sprinkler system			2011	1,250		15	83	83	803	23
24	100 Gallon Hot Water Heater			2011	5,605		15	374	374	4,020	24
25	Furnace Inducer			2012	742		15	49	49	468	25
26	Flooring-Women's Bathroom			2013	516		15	34	34	270	26
27	Replace Dry System Piping with Galvanized Piping			2014	4,903		15	327	327	2,452	27
28	Carpeting - Living Room, Activity Room and Small Office			2014	1,750		15	117	117	829	28
29	Bldg Repairs from Storm Damage (Gross of W/Off-Line 5)			2014	55,760		40	1,394	1,394	10,571	29
30	Repaired/Replaced Roof, Gutters, Downspouts, Gazebo,										30
31	Garage, Exterior Walls, Siding										31
32	New Gazebo			2014	3,398		15	227	227	1,570	32
33	Replaced mixing valve & piping water heater			2014	1,850		15	123	123	810	33
34	Replace bathroom shower faucet, tub & drain			2015	1,268		15	85	85	517	34
35	Replace 1" line;rebuild ck valves sprinkler system			2015	1,450		15	97	97	541	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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Reroute Hot Water to Kitchen	2016	$ 3,481	$	15	$ 232	$ 232	$ 1,179	37
38	Replace Hot Water Heater	2017	6,453		15	430	430	1,899	38
39	Replace AC Unit - Back end of Building	2017	4,618		15	308	308	1,258	39
40	Excavate/Grade/Pave/Stripe Parking Lot and Driveway	2019	10,300		15	687	687	1,030	40
41	Repair Deficiencies in Fire Protection-Install New Sprinklers	2021	2,542		15	26	26	26	41
42	Replace Dry Pendant Sprinkler Heads	2021	9,746		15	54	54	54	42
43									43
44									44
45									45
46									46
47	Financial Statement Depreciation			18,940			(18,940)		47
48									48
49									49
50									50
51	Allocated from Home Office		16,585			691	691	2,560	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)		$ 847,993	$ 18,940		$ 24,032	$ 5,092	$ 440,374	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: 7/1/20 Ending: 6/30/21

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	$ 5,757	$	$ 530	$ 530	5-10 Yrs	$ 4,307	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	19,911				5-10 Yrs	19,911	73
74	Allocated from Home Office	31,693		804	804		25,953	74
75	TOTALS	$ 57,361	$	$ 1,334	$ 1,334		$ 50,171	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	$ 18,441	$	$	$	5	$ 18,441	76
77	Resident Transportation	Capitalized Repairs	2017	1,698		340	340	5	1,388	77
78	Resident Transportation	2019 Dodge Grand Caravan	2019	43,475		8,695	8,695	5	21,257	78
79	Allocated from Home Office			3,150		732	732		2,401	79
80	TOTALS			$ 66,764	$	$ 9,767	$ 9,767		$ 43,487	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)	$ 1,000,004	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,940	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,133	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,193	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 534,032	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2022	$
13.	/2023	$
14.	/2024	$

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: $ 2,679 Description: Allocated from Home Office-Office Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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

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

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

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		18,713		18,713
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 18,713	$	$ 18,713
10	SUM OF line 9, col. 1 and 2 (e)	$ 18,713			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,860		1,860	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$ 1,860		$ 1,860	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

STATE OF ILLINOIS

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/21 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 337,568	$ 337,568	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,942)	154,966	154,966	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,999	18,999	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Reserves/Deposits	1,676	1,676	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 513,209	$ 513,209	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,886	13
14	Buildings, at Historical Cost	58,209	847,993	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	72,779	124,125	16
17	Accumulated Depreciation (book methods)	(58,148)	(534,032)	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 (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 92,840	$ 465,972	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 606,049	$ 979,181	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,536	$ 35,536	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,588	43,588	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,297	2,297	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Advances from DHS	48,181	48,181	36
37	Intercompany Payable	70,306	70,306	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 199,908	$ 199,908	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,142	16,142	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,142	$ 16,142	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 216,050	$ 216,050	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 389,999	$ 763,131	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 606,049	$ 979,181	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 246,536	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 246,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	143,463	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 143,463	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 389,999	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 721,396	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 721,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,221	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,221	23
	D. Non-Operating Revenue		
24	Contributions	1	24
25	Interest and Other Investment Income***	421	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 422	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Forgivess of PPP Loan**	149,156	28
28a	**Allocated from Home Office-See Pg 19B**	18,941	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 168,097	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 905,136	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	120,078	31
32	Health Care	255,616	32
33	General Administration	318,251	33
	B. Capital Expense		
34	Ownership	21,517	34
	C. Ancillary Expense		
35	Special Cost Centers	1,860	35
36	Provider Participation Fee	44,351	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 761,673	40
41	**Income before Income Taxes (line 30 minus line 40)****	143,463	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 143,463	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 721,396	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 721,396	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

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

Harris Place
0038240
6/30/21

SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Gain/ (Loss) on Sale of Fixed Assets	62
Rental Income	5,208
Workshop Reimbursements	13,671
Total Line 28a	**18,941**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,028	1,043	29,410	28.20	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	2,080	2,092	26,332	12.59	15
16	Dishwashers					16
17	Maintenance Workers	723	1,040	15,628	15.03	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,234	1,352	50,995	37.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	352	370	9,469	25.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,356	1,406	27,256	19.39	29
30	Habilitation Aides (DD Homes)	12,112	12,982	177,943	13.71	30
31	Medical Records					31
32	Other Health C: House Mgr	308	312	5,338	17.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,193	20,597	$ 342,371 *	$ 16.62	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	35	$ 2,041	L1, C3	35
36	Medical Director	Monthly	880	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	477	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	9	510	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	$ 3,908		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Durbin	Administrator	0	$ 15,701
Laura Depauw	Administrator	0	35,294
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 50,995

B. Administrative - Other

Description	Amount
Allocated from Progressive Housing, Inc.	$ 122,078
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 122,078

C. Professional Services

Vendor/Payee	Type	Amount
Paycor	Payroll Service	$ 4,184
Janet Scellato	Accounting Services	1,003
Sikich, LLP	Accounting Services	3,639
Harper Accounting Group, LLC	Accounting Services	164
Tracey Peloza, LTD	Accounting Services	2,850
Personnel Planners	UC Consultant	281
MVS, LLC	Appraisal For Corp Office	123
Therap, LLC	Computer Services	1,804
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 14,048

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,062
Unemployment Compensation Insurance	3,895
FICA Taxes	25,458
Employee Health Insurance	9,203
Employee Meals	3,166
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	159
Other Employee Benefits	22,243
Allocated from Home Office	11,700
TOTAL (agree to Schedule V, line 22, col.8)	$ 95,886

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 3)	20
Patient Background Checks	
Hiring Expense	3,153
SpyGlass Group	2,545
Miscellaneous Dues & Fees	820
Allocated from Home Office	6,825
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,363

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	203
Seminar Expense	359
Allocated from Home Office	2,900
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,462

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/20 Ending: 6/30/21

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?

(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. $ **2,359** 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. $ **44,351**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed 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. $ **3,166** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **100% Line 14**
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? **N/A**
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: **Sikich, LLP**

(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