

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0038240

Facility Name: Harris Place

Address: 209 Harris Road East Peoria 61611
Number City 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:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C (3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 7/1/2024 to 6/30/2025 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)
(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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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)		0	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,232							5,232	13
14	TOTALS	5,232							5,232	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 89.59%

D. How many bed reserve days during this year were paid by the Department? 105 (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 certified beds. number of certified beds _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 6/30/25 Fiscal Year: 6/30/25

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

Facility Name & ID Number Harris Place # 0038240 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	
	A. General Services											
1	Dietary	37,636	855	1,724	40,215		40,215		40,215			1
2	Food Purchase		58,741		58,741		58,741		58,741			2
3	Housekeeping		5,884		5,884		5,884		5,884			3
4	Laundry		3,345		3,345		3,345		3,345			4
5	Heat and Other Utilities			35,639	35,639		35,639		35,639			5
6	Maintenance	4,763	11,266	17,653	33,682		33,682		33,682			6
7	Other (specify):*											7
8	TOTAL General Services	42,399	80,091	55,016	177,506		177,506		177,506			8
	B. Health Care and Programs											
9	Medical Director			605	605		605		605			9
10	Nursing and Medical Records	361,665	5,615	197	367,477		367,477		367,477			10
10a	Therapy											10a
11	Activities		3,646		3,646		3,646		3,646			11
12	Social Services	1,757		881	2,638		2,638		2,638			12
13	CNA Training											13
14	Program Transportation			3,241	3,241		3,241		3,241			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	363,422	9,261	4,924	377,607		377,607		377,607			16
	C. General Administration											
17	Administrative	83,224		175,027	258,251		258,251	(175,027)	83,224			17
18	Directors Fees							5,449	5,449			18
19	Professional Services			13,334	13,334		13,334	4,693	18,027			19
20	Dues, Fees, Subscriptions & Promotions			6,247	6,247		6,247	2,757	9,004			20
21	Clerical & General Office Expenses	5,348	763	9,213	15,324		15,324	108,119	123,443			21
22	Employee Benefits & Payroll Taxes			179,894	179,894		179,894	28,658	208,552			22
23	Inservice Training & Education			833	833		833		833			23
24	Travel and Seminar			3,015	3,015		3,015	5,038	8,053			24
25	Other Admin. Staff Transportation			1,270	1,270		1,270	454	1,724			25
26	Insurance-Prop.Liab.Malpractice			21,052	21,052		21,052	514	21,566			26
27	Other (specify):*											27
28	TOTAL General Administration	88,572	763	409,885	499,220		499,220	(19,345)	479,875			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	494,393	90,115	469,825	1,054,333		1,054,333	(19,345)	1,034,988			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			11,118	11,118		11,118	26,237	37,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			136	136		136	(136)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							7,057	7,057			34
35	Rent-Equipment & Vehicles							3,411	3,411			35
36	Other (specify):*											36
37	TOTAL Ownership			11,254	11,254		11,254	36,569	47,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		11,637		11,637		11,637		11,637			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,522	57,522		57,522		57,522			42
43	Other (specify):* Disallowed Costs			19,669	19,669		19,669	(19,669)				43
44	TOTAL Special Cost Centers		11,637	77,191	88,828		88,828	(19,669)	69,159			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	494,393	101,752	558,270	1,154,415		1,154,415	(2,445)	1,151,970			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.)

	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	21,249	30		9
10	Interest and Other Investment Income	(136)	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	(2,529)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,669)	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	(1,360)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,445)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,445)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (315)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallowed HO Costs	(1,503)	43	3
4	Offset Miscellaneous Income	(44)	21	4
5	Offset Rental Income	(4,261)	34	5
6	Nonallowable Home Office Legal Fees	(225)	19	6
7	Home Office Depreciation Expense	4,988	30	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
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26				26
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28				28
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,360)		49

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	\$	Progressive Housing, Inc.	100.00%	\$ 0	\$	1
2	V	18	Director Fees		Progressive Housing, Inc.	100.00%	5,449	5,449	2
3	V	19	Professional Services		Progressive Housing, Inc.	100.00%	7,447	7,447	3
4	V	20	Dues, Fees, Subs and Promotions		Progressive Housing, Inc.	100.00%	3,072	3,072	4
5	V	21	Clerical and General Office		Progressive Housing, Inc.	100.00%	108,163	108,163	5
6	V	22	Employee Benefits		Progressive Housing, Inc.	100.00%	28,658	28,658	6
7	V	24	Travel and Seminar		Progressive Housing, Inc.	100.00%	5,038	5,038	7
8	V	25	Auto Expense		Progressive Housing, Inc.	100.00%	454	454	8
9	V	26	Insurance		Progressive Housing, Inc.	100.00%	514	514	9
10	V	33	Real Estate Taxes		Progressive Housing, Inc.	100.00%	0		10
11	V	34	Rent-Facility		Progressive Housing, Inc.	100.00%	11,318	11,318	11
12	V	35	Equipment Rental		Progressive Housing, Inc.	100.00%	3,411	3,411	12
13	V								13
14	Total			\$			\$ 173,524	\$ * 173,524	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%	\$ 1,503	\$ 1,503	15
16	V	17	Administrative	175,027	Progressive Housing, Inc.	100.00%		(175,027)	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			\$ 175,027			\$ 1,503	\$ * (173,524)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Briarbrook	East Peoria	Progressive Careers			3
4			Joshua Manor	Hoyleton	& Housing	Country Club Hills	Workshop	4
5			Park Place	Pana	Progressive Careers			5
6			Aviston Terrace	Aviston	& Housing	University Park	Workshop	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			Huron	Park Forest				20
21			Wilshire	Park Forest				21
22			175th Place	Country Club Hills				22
23			Burnham	University Park				23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	\$ 546	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	546	L18,C8	2
3	Hal Brown	Secretary	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	546	L18,C8	3
4	Cora Flota	Director	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	546	L18,C8	4
5	Edward Copeland	Director	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	546	L18,C8	5
6	Eileen Mullin	Director	Board Member	None	9,054	3Hrs/MTG	1.00	Dir. Fees	546	L18,C8	6
7	Julie Lilie	Director	Board Member	None	9,055	3Hrs/MTG	1.00	Dir. Fees	545	L18,C8	7
8	Eugene Dumas	Director	Board Member	None	9,055	3Hrs/MTG	1.00	Dir. Fees	545	L18,C8	8
9											9
10											10
11						Misc Expenses			1,083		11
12											12
13								TOTAL	\$ 5,449		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

Ending: 5/30/2025

(708) 283-2470

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10									Misc Interest			136	10
11									Interest Income Offset			(136)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Facility	47,250	1999	\$ 20,000	1
2	Allocated from Home Office			7,954	2
3	TOTALS	47,250		\$ 27,954	3

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	\$ 480,614
5				2013	(39,426)		40	(986)	(986)	(25,384)
6										
7										
8										
	Improvement Type**									
9	Carpeting		1999		2,183		15			2,183
10	Drive Repaving		2004		1,498		15			1,498
11	Bathroom Carpet		2006		945		15			945
12	Carpeting (Replaced-See Line 28 below)		2006				15			
13	Batheoom Toilets		2006		1,026		15			1,026
14	Bathroom Remodel		2006		5,100		15			5,100
15	Bathroom Remodel		2006		3,043		15			3,043
16	Bathroom Remodel		2007		3,355		15			3,355
17	Gazebo		2007		1,896		15			1,896
18	Concrete Sidewalk		2009		2,255		15			2,255
19	Repair the Water Line to Showers		2009		2,562		15	72	72	2,562
20	Bedroom Carpeting		2010		565		15	30	30	565
21	Bathroom Remodel		2010		430		15	22	22	430
22	Exterior Door for Facility		2010		344		15	14	14	344
23	Replace air compressor in sprinkler system		2011		1,250		15	83	83	1,135
24	100 Gallon Hot Water Heater		2011		5,605		15	374	374	5,516
25	Furnace Inducer		2012		742		15	49	49	664
26	Flooring-Women's Bathroom		2013		516		15	34	34	406
27	Replace Dry System Piping with Galvanized Piping		2014		4,903		15	327	327	3,760
28	Carpeting - Living Room, Activity Room and Small Office		2014		1,750		15	117	117	1,297
29	Bldg Repairs from Storm Damage (Gross of W/Off-Line 5)		2014		55,760		40	1,394	1,394	16,147
30	Repaired/Replaced Roof, Gutters, Downspouts, Gazebo,									
31	Garage, Exterior Walls, Siding									
32	New Gazebo		2014		3,398		15	227	227	2,478
33	Replaced mixing valve & piping water heater		2014		1,850		15	123	123	1,302
34	Replace bathroom shower faucet, tub & drain		2015		1,268		15	85	85	857
35	Replace 1" line;rebuild ck valves sprinkler system		2015		1,450		15	97	97	929
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

Facility Name & ID Number Harris Place

0038240

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	\$ 2,107	37
38	Replace Hot Water Heater	2017	6,453		15	430	430	3,620	38
39	Replace AC Unit - Back end of Building	2017	4,618		15	308	308	2,489	39
40	Excavate/Grade/Pave/Stripe Parking Lot and Driveway	2019	10,300		15	687	687	3,778	40
41	Repair Deficiencies in Fire Protection-Install New Sprinklers	2021	2,542		15	169	169	702	41
42	Replace Dry Pendant Sprinkler Heads	2021	9,746		15	650	650	2,654	42
43	New Trane 2 Stage Furnace	2022	6,930		15	462	462	1,309	43
44	New Flooring Installed in Hallways/Living Room/Dining Room	2023	5,291		15	353	353	774	44
45	Paint Common Area Walls/Ceilings/Fix Cracks & Holes	2023	4,150		15	277	277	415	45
46	Replaced Air Compressor and Repair Leaks in Attic	2023	6,376		15	425	425	638	46
47	Install New Fire Alarm System	2024	4,613		20	115	115	115	47
48	Install New Flooring-Great Room	2024	2,832		10	142	142	142	48
49	Facility Remodel:	2025	289,864		20	7,247	7,247	7,247	49
50	Kitchen - Install New Kitchen Cabinets & Countertops/								50
51	New Flooring/Paint/New Windows/Fixtures/Exterior Doors								51
52	New Exterior Lights with Sensors								52
53	New Flooring/Lighting in Common Areas								53
54	Bathrooms - New Vanities/Showers/Plumbing/Electrical/								54
55	Paint/Fixtures								55
56	Laundry Rm - Flooring/Paint/Electrical/Cabinets/Appliances								56
57	Paint and Trimwork Where Needed								57
58	Fireplace - Clean & Replace Mantel & Stone								58
59									59
60									60
61									61
62									62
63	Financial Statement Depreciation			11,118			(11,118)		63
64									64
65	Allocated from Home Office		41,738					9,747	65
66									66
67	Home Office Depreciation Expense Allocation					3,116	3,116		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,193,202	\$ 11,118		\$ 34,925	\$ 23,807	\$ 550,660	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,777	\$	\$ 320	\$ 320	5-10 Yrs	\$ 1,045	71
72	Current Year Purchases	4,754		238	238	10 Yrs	238	72
73	Fully Depreciated Assets	25,089				5-10 Yrs	25,089	73
74	Home Office Allocation	37,177		1,183	1,183		29,437	74
75	TOTALS	\$ 70,797	\$	\$ 1,741	\$ 1,741		\$ 55,809	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				5	1,698	77
78										78
79	Allocated from Home Office			7,625		689	689	5	4,462	79
80	TOTALS			\$ 27,764	\$	\$ 689	\$ 689		\$ 24,601	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 1,319,717	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,118	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,355	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,237	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 631,070	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Home Office				11,318			5
6	Income Offset				(4,261)			6
7	TOTAL				\$ 7,057			7

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

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: \$ 3,411
- 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.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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				11,637		11,637	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 11,637		\$ 11,637	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$330,839	\$330,839	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance89,085)	231,507	231,507	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,060	1,060	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposits	1,704	1,704	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$565,110	\$565,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	27,954	13
14	Buildings, at Historical Cost	372,493	1,193,202	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	29,304	98,561	16
17	Accumulated Depreciation (book methods)	(60,770)	(631,070)	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)	\$361,027	\$688,647	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$926,137	\$1,253,757	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$34,991	\$34,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,326	42,326	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,955	1,955	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				36
37	Intercompany Payable	773,330	773,330	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$852,602	\$852,602	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$852,602	\$852,602	46
47	TOTAL EQUITY(page 18, line 24)	\$73,535	\$401,155	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$926,137	\$1,253,757	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 188,553	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 188,553	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(115,018)	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)	\$ (115,018)	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)	\$ 73,535	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Harris Place

0038240

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,062,520	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,062,520	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	1,609	24
25	Interest and Other Investment Income***	7,475	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,084	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Pg 19B	(32,207)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (32,207)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,039,397	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	177,506	31
32	Health Care	377,607	32
33	General Administration	499,220	33
	B. Capital Expense		
34	Ownership	11,254	34
	C. Ancillary Expense		
35	Special Cost Centers	31,306	35
36	Provider Participation Fee	57,522	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,154,415	40
41	Income before Income Taxes (line 30 minus line 40)**	(115,018)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (115,018)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,062,520.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,062,520	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name

Facility ID

Period Ending

Harris Place

0038240

6/30/2025

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

Facility ID

Period Ending

Harris Place

0038240

6/30/2025

SCH 19B

XVII. INCOME STATEMENT

Line 28a. Income Allocated from Home Office

Miscellaneous Income	44
Rental Income	4,261
Workshop Reimbursement/Disbursements	(36,512)

Total Line 28a

(32,207)

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	255	266	10,440	39.25	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	51	51	1,757	34.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,642	1,817	37,636	20.71	15
16	Dishwashers					16
17	Maintenance Workers	207	231	4,763	20.62	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,697	1,815	83,224	45.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	149	165	5,348	32.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	141	141	3,497	24.80	28
29	Resident Services Coordinator	2,040	2,080	48,809	23.47	29
30	Habilitation Aides (DD Homes)	12,855	13,772	298,919	21.70	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,037	20,338	\$ 494,393 *	\$ 24.31	34

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	Monthly	\$ 1,724	L1, C3	35
36	Medical Director	Monthly	605	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	192	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	Monthly	881	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 3,402		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Deziree Danyel Vaughn	Administrator	0	\$ 83,224	Workers' Compensation Insurance	\$	23,893	IDPH License Fee	\$	
				Unemployment Compensation Insurance		10,189	Advertising: Employee Recruitment		
				FICA Taxes		36,892	Health Care Worker Background Check		
				Employee Health Insurance		79,112	(Indicate # of checks performed 5)	1,387	
				Employee Meals		9,341	Patient Background Checks	3 750	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	1,556	
				Life Insurance		2,170	Hiring Expense	3,090	
				Other Employee Benefits		6,909	Miscellaneous Licenses & Fees	319	
				Union Dues		11,388	Miscellaneous Dues & Subs	1,576	
							WIPFLI	641	
							Less: Public Relations Expense	()	
							PAC and Lobbying payments	(315)	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,004	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Allocated from Progressive Housing, Inc.			\$ 175,027			\$	Out-of-State Travel	\$	
							In-State Travel	2,099	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
C. Professional Services	Type		Amount						
Barbara Weiner	Compliance Consultant		\$ 103						
Tracey Peloza, LTD	Accounting Services		3,293						
Sikich, LLP	Accounting Services		3,399						
Personnel Planners	UC Consultant		252						
David A Ring & Associates	Land Surveyor		172						
Annette Skafgaard	Accts Receivable Consultant		634						
Neil Gerber	Accounting Services		62						
Wipfli	Accounting Services		58				Seminar Expense	916	
							Allocated from Home Office	5,038	
See Attached	Legal Services		5,361				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
							\$ 8,053		

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

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes-DSP
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	623
Other, please specify Inst on Public Policy for People w Disabilti	618
	1,241 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	315
Other, please specify Inst on Public Policy for People w Disabilities	
	315 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	938
Other, please specify Inst on Public Policy for People w Disabilti	618
	1,556 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$5,505

Line10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$57,522

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$9,341

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (12)

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: Sikich, LLP
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

Yes

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.