		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility 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: 371238076006

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©(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROB KEIME Telephone Number: 309-685-0595 EXT. 304

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2005 to 06/30/2006 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) VINCENT EVERSON
	(Title) PRESIDENT & CEO
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) 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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,769			5,769	13
14	TOTALS	5,769			5,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.78%

D. How many bed-hold days during this year were paid by the Department?
71 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

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 10/01/1992

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 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	14,991	1,864	1,947	18,802		18,802		18,802			1
2	Food Purchase		21,092		21,092		21,092		21,092			2
3	Housekeeping		1,728	560	2,288		2,288		2,288			3
4	Laundry		756		756		756		756			4
5	Heat and Other Utilities			12,244	12,244		12,244		12,244			5
6	Maintenance	7,849		9,646	17,495		17,495	(1,843)	15,652			6
7	Other (specify):*											7
8	TOTAL General Services	22,840	25,440	24,397	72,677		72,677	(1,843)	70,834			8
	B. Health Care and Programs											
9	Medical Director			660	660		660		660			9
10	Nursing and Medical Records	155,984	4,564	2,372	162,920		162,920		162,920			10
10a	Therapy			290	290		290		290			10a
11	Activities		1,324		1,324		1,324		1,324			11
12	Social Services			1,311	1,311		1,311		1,311			12
13	CNA Training	1,158	35		1,193		1,193		1,193			13
14	Program Transportation			2,206	2,206		2,206		2,206			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	157,142	5,923	6,839	169,904		169,904		169,904			16
	C. General Administration											
17	Administrative	7,846		37,427	45,273		45,273		45,273			17
18	Directors Fees			3,618	3,618		3,618		3,618			18
19	Professional Services			8,881	8,881		8,881		8,881			19
20	Dues, Fees, Subscriptions & Promotions			1,643	1,643		1,643		1,643			20
21	Clerical & General Office Expenses		2,443	6,339	8,782		8,782		8,782			21
22	Employee Benefits & Payroll Taxes			51,666	51,666		51,666		51,666			22
23	Inservice Training & Education			4,303	4,303		4,303		4,303			23
24	Travel and Seminar			80	80		80		80			24
25	Other Admin. Staff Transportation			1,281	1,281		1,281		1,281			25
26	Insurance-Prop.Liab.Malpractice			6,252	6,252		6,252		6,252			26
27	Other (specify):*											27
28	TOTAL General Administration	7,846	2,443	121,490	131,779		131,779		131,779			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	187,828	33,806	152,726	374,360		374,360	(1,843)	372,517			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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: 07/01/2005 Ending: 06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,937	23,937		23,937	2,924	26,861			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,707	103,707		103,707	(5,371)	98,336			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			933	933		933		933			34
35	Rent-Equipment & Vehicles			643	643		643		643			35
36	Other (specify):*											36
37	TOTAL Ownership			129,220	129,220		129,220	(2,447)	126,773			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,343	41,343		41,343		41,343			42
43	Other (specify):*			201,326	201,326		201,326	(201,326)				43
44	TOTAL Special Cost Centers			242,669	242,669		242,669	(201,326)	41,343			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	187,828	33,806	524,615	746,249		746,249	(205,616)	540,633			45

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(200,973)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,338)	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	(33)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(353)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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 LOSS ON DISPOSAL OF ASSETS	1,081			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (205,616)		$	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))**	$ (205,616)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HARRIS PLACE

ID# 0038240

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	(1,843)	0	0	0	0	0	0	(1,843)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	(1,843)	0	0	0	0	0	0	(1,843)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	(1,843)	0	0	0	0	0	0	(1,843)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	1,843	0	0	0	0	0	0	1,843	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,371)	0	0	0	0	0	0	0	0	0	0	(5,371)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,371)	0	0	0	1,843	0	0	0	0	0	0	(3,528)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(201,326)	0	0	0	0	0	0	0	0	0	0	(201,326)	43
44	TOTAL Special Cost Centers	(201,326)	0	0	0	0	0	0	0	0	0	0	(201,326)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(206,697)	0	0	0	0	0	0	0	0	0	0	(206,697)	45

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 ATTACHED RELATED PARTY SCHEDULE		SEE ATTACHED RELATED PARTY SCHEDULE		
SEE ATTACHED SCHEDULE 7A						

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	18	BOARD FEES	$ 2,259	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	$ 2,259	$	1
2	V	19	PROFESSIONAL FEES	4,134	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	4,134		2
3	V	20	LICENSE, DUES	120	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	120		3
4	V	21	GENERAL OFFICE	1,025	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	1,025		4
5	V	23	INSERVICE TRAVEL	234	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	234		5
6	V	32	INTEREST	4,358	PROGRESSIVE HOUSING, INC. 07/05 to 03/31/06	100.00%	4,358		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 12,130			$ 12,130	$ *	14

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	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	18	BOARD FEES	$ 420	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	$ 420	$	15
16	V	19	PROFESSIONAL FEES	407	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	407		16
17	V	21	OFFICE SUPPLIES	216	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	216		17
18	V	22	INSERVICE TRAVEL	47	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	47		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			$ 1,090			$ 1,090	$ *	39

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	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	18	BOARD FEES	$ 188	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	$ 188	$	15
16	V	19	PROFESSIONAL FEES	751	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	751		16
17	V	21	OFFICE SUPPLIES	86	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	86		17
18	V	22	INSERVICE TRAVEL	21	PROGRESSIVE HOUSING, INC. 06/01/06 TO 06/30/06	100.00%	21		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			$ 1,046			$ 1,046	$ *	39

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	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	17	ADMINISTRATIVE COST	$ 37,368	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO	$ 37,368	$	15
16	V	18	DIRECTORS FEES	751	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	751		16
17	V	19	PROFESSIONAL FEES	1,230	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,230		17
18	V	20	DUES, FEES	426	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	426		18
19	V	22	EMPLOYEE BENEFITS	7,290	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	7,290		19
20	V	23	INSERVICE EDUCATION	1,765	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,765		20
21	V	24	TRAVEL SEMINAR	39	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	39		21
22	V	26	INSURANCE	898	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	898		22
23	V	30	DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,843	1,843	23
24	V	32	INTEREST	279	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	279		24
25	V	34	RENT	933	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	933		25
26	V	35	EQUIPMENT RENTAL	60	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	60		26
27	V	5	UTILITIES	472	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	472		27
28	V	6	MAINTENANCE	2,067	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	224	(1,843)	28
29	V	43	NONALLOWABLE	353	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	353		29
30	V	32	INTEREST INCOME	(35)	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(35)		30
31	V	32	MISC INCOME	(1,825)	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	(1,825)		31
32	V	3	HOUSEKEEPING	134	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	134		32
33	V	21	OFFICE	1,246	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,246		33
34	V	11	ACTIVITIES	11	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	11		34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,462			$ 53,462	$ *	39

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	RONALD SCHROEDER	SECRETARY	BOARD MEMBEI	NONE	11,322	3HRS/MTG	1.00	DIR. FEES	$ 678	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBEI	NONE	10,559	3HRS/MTG	1.00	DIR. FEES	641	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBEI	NONE	11,322	3HRS/MTG	1.00	DIR. FEES	678	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBEI	NONE	4,630	3HRS/MTG	1.00	DIR. FEES	170	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBEI	NONE	4,348	3HRS/MTG	1.00	DIR. FEES	452	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBEI	NONE	8,922	3HRS/MTG	1.00	DIR. FEES	678	L18, C8	6
7	KAY SCHUMAN JOHNSON	DIRECTOR	BOARD MEMBEI	NONE	2,879	3HRS/MTG	1.00	DIR. FEES	321	L18, C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,618		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.

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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: 2020 W. WARMEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	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	18	BOARD FEES	NUMBER OF BEDS	136	12	$ 19,200	$	16	$ 2,259	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	136	12	35,139		16	4,134	2
3	20	LICENSE, DUES	NUMBER OF BEDS	136	12	1,015		16	120	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	136	12	8,713		16	1,025	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	136	12	1,989		16	234	5
6	32	INTEREST	NUMBER OF BEDS	136	12	37,045		16	4,358	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 103,101	$		$ 12,130	25

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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: 2020 W. WARMEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	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	18	BOARD FEES	NUMBER OF BEDS	335	17	$ 8,800	$	16	$ 420	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	335	17	8,515		16	407	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	335	17	4,516		16	216	3
4	22	INSERVICE TRAVEL	NUMBER OF BEDS	335	17	989		16	47	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 22,820	$		$ 1,090	25

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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: 2020 W. WARMEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 61614
Phone Number: (309)685-0595
Fax Number: (309)685-8463

	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	18	BOARD FEES	NUMBER OF BEDS	341	18	$ 4,000	$	16	$ 188	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	341	18	16,013		16	751	2
3	21	OFFICE SUPPLIES	NUMBER OF BEDS	341	18	1,838		16	86	3
4	22	INSERVICE TRAVEL	NUMBER OF BEDS	341	18	445		16	21	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 22,296	$		$ 1,046	25

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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: CENTER FOR RESIDENTIAL MANAGEMENT
Street Address: 2020 W. WAR MEMORIAL DR. SUITE 103
City / State / Zip Code: PEORIA, IL. 616147
Phone Number: (309-685-0595
Fax Number: (309-685-8463

	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	17	ADMINISTRATIVE COST	NUMBER OF BEDS	341	18	$ 796,413	$ 715,898	16	$ 37,368	1
2	18	DIRECTORS FEES	NUMBER OF BEDS	341	18	16,000		16	751	2
3	19	PROFESSIONAL FEES	NUMBER OF BEDS	341	18	26,217		16	1,230	3
4	20	DUES, FEES	NUMBER OF BEDS	341	18	9,084		16	426	4
5	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	341	18	155,362		16	7,290	5
6	23	INSERVICE EDUCATION	NUMBER OF BEDS	341	18	37,610		16	1,765	6
7	24	TRAVEL SEMINAR	NUMBER OF BEDS	341	18	825		16	39	7
8	26	INSURANCE	NUMBER OF BEDS	341	18	19,152		16	898	8
9	30	DEPRECIATION	NUMBER OF BEDS	341	18	39,276		16	1,843	9
10	32	INTEREST	NUMBER OF BEDS	341	18	5,951		16	279	10
11	34	RENT	NUMBER OF BEDS	341	18	19,876		16	933	11
12	35	EQUIPMENT RENTAL	NUMBER OF BEDS	341	18	1,280		16	60	12
13	5	UTILITIES	NUMBER OF BEDS	341	18	10,053		16	472	13
14	6	MAINTENANCE	NUMBER OF BEDS	341	18	4,785		16	224	14
15	43	NONALLOWABLE	NUMBER OF BEDS	341	18	7,517		16	353	15
16	32	INTEREST INCOME	NUMBER OF BEDS	341	18	(755)		16	(35)	16
17	32	MISC INCOME	NUMBER OF BEDS	341	18	(38,904)		16	(1,825)	17
18	3	HOUSEKEEPING	NUMBER OF BEDS	341	18	2,847		16	134	18
19	21	OFFICE	NUMBER OF BEDS	341	18	26,574		16	1,246	19
20	11	ACTIVITIES	NUMBER OF BEDS	341	18	243		16	11	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,139,406	$ 715,898		$ 53,462	25

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	BANK ONE/MARINE BANK BOND		X	ACQUISITION OF FACILITY	$20,271.53	06/25/98	$ 20,272	$	03/09/06	VARIES	$ 80,337	1
2	IL. HEALTH FAC AUTH. BOND		X	FACILITY ACQUISITION	VARIES	03/09/06	692,503	692,503	08/15/26	6.7500	16,506	2
3	BANTERRA BANK		X	VAN PURCHASE	$444.00	09/30/05	14,414	11,030	09/30/08	6.7500	612	3
4												4
5												5
	Working Capital											
6	HEALTHCARE BUSINESS CREDIT		X	WORKING CAPITAL		5/12/2003	286,000		03/09/06	10.5000	5,940	6
7				OFFSET INTERST INCOME/ NONALLOWABLE INT.							(5,338)	7
8				MISC./PARENT ALLOCATION							279	8
9	TOTAL Facility Related				$20,715.53		$ 1,013,189	$ 703,533			$ 98,336	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,013,189	$ 703,533			$ 98,336	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NO 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.)

** 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: 07/01/2005 Ending: 06/30/2006

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.	$ N/A	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).	$ #VALUE!	3
4. Real Estate Tax accrual used for 2006 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.	$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2001		8
2002		9
2003		10
2004		11
2005		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HARRIS PLACE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0038240

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

	(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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered 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: 07/01/2005 Ending: 06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior BRICK/VINYL SIDIN 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).

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RESIDENT CARE	47,250	1999	$ 20,000	1
2					2
3	TOTALS	47,250		$ 20,000	3

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1999	1991	$ 730,000	$ 18,250	40	$ 18,250	$	$ 133,833	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARENT ALLOCATION			1997	5						9
10	CARPETING			1999	2,178	146	15	146		1,092	10
11	DRIVE REPAVING			2004	1,498	100	15	100		191	11
12	BATHROOM CARPET			2006	945	5	15	5		5	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									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)		$ 734,626	$ 18,501		$ 18,501	$	$ 135,121	70

**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: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 17,560	$ 1,996	$ 1,996	$	5-10 YRS	$ 9,884	71
72	Current Year Purchases	932	32	32		5-10 YRS	32	72
73	Fully Depreciated Assets	1,829				5	1,829	73
74								74
75	TOTALS	$ 20,321	$ 2,028	$ 2,028	$		$ 11,745	75

D. Vehicle Depreciation (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	FACILITY USE	96 CHEVY LUMINA	2002	$	$ 200	$ 200	$	5	$	76
77	FACILITY USE	96 DODGE VAN	2002	3,500	700	700		5	2,917	77
78	FACILITY USE	REPAIR TO DODGE VAN	2004	724	73	73		5	326	78
79	FACILITY USE	2005 DODGE VAN	2005	14,612	2,435	2,435		5	2,435	79
80	TOTALS			$ 18,836	$ 3,408	$ 3,408	$		$ 5,678	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)	$ 793,783	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,937	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,937	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 152,544	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					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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.

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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		SEE SCH 6C			933			5
6								6
7	TOTAL				$ 933 **			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: *

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.	/2007	$
13.	/2008	$
14.	/2009	$

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: $ 643 Description: SEE SCH 6C, WATER SOFTNER, WHEEL CHAIR
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		35		35
3	Classroom Wages (a)		336		336
4	Clinical Wages (b)		822		822
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,193	$	$ 1,193
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,193			

(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.

$ (2,939)

D. NUMBER OF CNAs TRAINED

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

(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.

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2006 (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	$ 400	$	1
2	Cash-Patient Deposits	2,697		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 785)	205,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72		6
7	Other Prepaid Expenses	152		7
8	Accounts Receivable (owners or related parties)	1,092,982		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,302,043	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	730,000		14
15	Leasehold Improvements, at Historical Cost	4,626		15
16	Equipment, at Historical Cost	39,157		16
17	Accumulated Depreciation (book methods)	(152,544)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	111,830		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	21,871		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 774,940	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,076,983	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,451	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,697		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,963		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,396		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 104,507	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,030		39
40	Mortgage Payable			40
41	Bonds Payable	692,503		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME BONDS	30,343		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 733,876	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 838,383	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,238,600	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,076,983	$	48

*(See instructions.)

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,055,525	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,055,525	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	183,075	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)**	$ 183,075	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)**	$ 1,238,600	24 *

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 723,626	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 723,626	3
	B. Ancillary Revenue		
4	Day Care	200,973	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 200,973	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(2,939)	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)**	$ (2,939)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,338	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,338	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SETTLEMENT OF LEGAL COST	3,407	28
28a	LOSS ON DISPOSAL OF ASSETS	(1,081)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,326	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 929,324	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	72,677	31
32	Health Care	169,904	32
33	General Administration	131,779	33
	B. Capital Expense		
34	Ownership	129,220	34
	C. Ancillary Expense		
35	Special Cost Centers	201,326	35
36	Provider Participation Fee	41,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 746,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	183,075	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 183,075	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	179	179	4,194	23.43	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	138	138	1,158	8.39	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,676	1,837	14,991	8.16	15
16	Dishwashers					16
17	Maintenance Workers	775	813	7,849	9.65	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	453	459	7,846	17.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	824	833	11,194	13.44	28
29	Resident Services Coordinator	690	679	13,323	19.62	29
30	Habilitation Aides (DD Homes)	14,408	15,163	127,273	8.39	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,143	20,101	$ 187,828 *	$ 9.34	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	32	$ 1,947	L1, C3	35
36	Medical Director	MONTHLY	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	290	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	23	1,311	L12, C3	45
46	Other(specify)				46
47	PSYCHOLOGICAL	15	1,455	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	77	$ 5,663		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA MEADS	ADMINISTRATOR	0	$ 7,846
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 7,846

B. Administrative - Other

Description	Amount
MANAGEMENT FEES ADJ ON SCHEDULE 6A	$ 37,368
PERSONNEL PLANNERS, INC UC CONSULTATION	12
NCCI HOLDING W/C INS REVIEW	47
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 37,427

C. Professional Services

Vendor/Payee	Type	Amount
JONES DAY	LEGAL	$ 53
LAWRENCE MANSON	LEGAL	1,037
HBCC	ACCOUNTING	360
HEINOLD-BANWART	ACCOUNTING	3,842
WESTERVELT JOHNSON	LEGAL	11
LAWRENCE MANSON	LEGAL	626
HEINOLD-BANWART	ACCOUNTING	573
ROUND TABLE DESIGN	SURVEY	20
MARINE BANK/WELLS FARGO	BOND TRUSREE FEES	1,759
PERSONNEL PLANNERS, INC UC	CONSULTATION	600
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,611
Unemployment Compensation Insurance	6,473
FICA Taxes	16,628
Employee Health Insurance	15,125
Employee Meals	4,886
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE MORAL	898
EMPLOYEE PHYSICALS	45
TOTAL (agree to Schedule V, line 22, col.8)	$ 51,666

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 118
Advertising: Employee Recruitment		609
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks	37	373
VEHICLE LICENSE		65
MISCELLANEOUS DUES & FEES		428
ADMINISTRATOR LICENSE		50
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 1,643

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
BASIL BEHAVOIR ANALYSIS	12
Seminar Expense	
APPLES & ORANGES	29
BASIL BEHAVOIR ANALYSIS	39
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 80

**See instructions.

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **776** 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. $ **41,343**
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.

(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. $ **4,886** 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? **90%**
d. Have vehicle usage logs been maintained? **ADEQUATE RECORDS ARE 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? ____
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HEINOLD - BANWART, LTD.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

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

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.