

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 371238076006

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501©3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

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 07/01/2006 to 06/30/2007 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) <u>VINCENT EVERSON</u>	
	(Title) <u>PRESIDENT & CEO</u>	
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: 07/01/2006 Ending: 06/30/2007

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	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>5,061</u>	<u>50</u>		<u>5,111</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>5,061</u>	<u>50</u>		<u>5,111</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.52%

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

79 (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)

NONEF. 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

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 10/01/1992

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

YES Date 03/08/1999 NO

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

YES NO If YES, enter number of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	14,710	1,891	1,925	18,526		18,526		18,526		1
2	Food Purchase		18,544		18,544		18,544		18,544		2
3	Housekeeping		1,580		1,580		1,580	240	1,820		3
4	Laundry		526	308	834		834		834		4
5	Heat and Other Utilities			12,888	12,888		12,888	779	13,667		5
6	Maintenance	9,541		9,926	19,467		19,467	467	19,934		6
7	Other (specify):*										7
8	TOTAL General Services	24,251	22,541	25,047	71,839		71,839	1,486	73,325		8
	B. Health Care and Programs										
9	Medical Director			660	660		660		660		9
10	Nursing and Medical Records	168,577	2,815	9,512	180,904		180,904	25	180,929		10
10a	Therapy			330	330		330		330		10a
11	Activities		2,440		2,440		2,440	(93)	2,347		11
12	Social Services			542	542		542		542		12
13	CNA Training	2,231		60	2,291		2,291		2,291		13
14	Program Transportation			1,727	1,727		1,727		1,727		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	170,808	5,255	12,831	188,894		188,894	(68)	188,826		16
	C. General Administration										
17	Administrative	5,419			5,419		5,419	35,876	41,295		17
18	Directors Fees			2,737	2,737		2,737		2,737		18
19	Professional Services			5,105	5,105		5,105	63	5,168		19
20	Dues, Fees, Subscriptions & Promotions			2,499	2,499		2,499	490	2,989		20
21	Clerical & General Office Expenses		641	12,126	12,767		12,767	1,174	13,941		21
22	Employee Benefits & Payroll Taxes			35,908	35,908		35,908	7,757	43,665		22
23	Inservice Training & Education			3,132	3,132		3,132	2,151	5,283		23
24	Travel and Seminar			588	588		588	256	844		24
25	Other Admin. Staff Transportation			97	97		97		97		25
26	Insurance-Prop.Liab.Malpractice			4,193	4,193		4,193	1,353	5,546		26
27	Other (specify):*										27
28	TOTAL General Administration	5,419	641	66,385	72,445		72,445	49,120	121,565		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	200,478	28,437	104,263	333,178		333,178	50,538	383,716		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: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	D. Ownership											
30	Depreciation			24,790	24,790	24,790	2,271	27,061				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,157	50,157	50,157	(9,829)	40,328				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						1,444	1,444				34
35	Rent-Equipment & Vehicles			550	550	550	97	647				35
36	Other (specify):*											36
37	TOTAL Ownership			75,497	75,497	75,497	(6,017)	69,480				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			43,416	43,416	43,416		43,416				42
43	Other (specify):*			181,804	181,804	181,804	(181,804)					43
44	TOTAL Special Cost Centers			225,220	225,220	225,220	(181,804)	43,416				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	200,478	28,437	404,980	633,895	633,895	(137,283)	496,612				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: 07/01/2006

Ending: 06/30/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(181,804)	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	(10,010)	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	(130)	32		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	(784)	43		18
19	Entertainment				19
20	Contributions	(93)	11		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,125)	21		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (196,946)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (196,946)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY						
48		49		50		51
						52

HARRIS PLACE

ID# 0038240
 Report Period Beginning: 07/01/2006
 Ending: 06/30/2007

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:

07/01/2006

Ending:

06/30/2007

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	240	0	0	0	0	0	0	0	0	240	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	779	0	0	0	0	0	0	0	0	779	5
6	Maintenance	0	0	467	0	0	0	0	0	0	0	0	467	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	1,486	0	0	0	0	0	0	0	0	1,486	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	25	0	0	0	0	0	0	0	0	25	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(93)	0	0	0	0	0	0	0	0	0	0	(93)	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	(93)	0	25	0	0	0	0	0	0	0	0	(68)	16
	C. General Administration													
17	Administrative	0	0	35,876	0	0	0	0	0	0	0	0	35,876	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	63	0	0	0	0	0	0	0	0	63	19
20	Fees, Subscriptions & Promotions	0	0	490	0	0	0	0	0	0	0	0	490	20
21	Clerical & General Office Expenses	(4,125)	0	5,299	0	0	0	0	0	0	0	0	1,174	21
22	Employee Benefits & Payroll Taxes	0	0	7,757	0	0	0	0	0	0	0	0	7,757	22
23	Inservice Training & Education	0	0	2,151	0	0	0	0	0	0	0	0	2,151	23
24	Travel and Seminar	0	0	256	0	0	0	0	0	0	0	0	256	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	1,353	0	0	0	0	0	0	0	0	1,353	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,125)	0	53,245	0	0	0	0	0	0	0	0	49,120	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,218)	0	54,756	0	0	0	0	0	0	0	0	50,538	29

STATE OF ILLINOIS

Facility Name & ID Number HARRIS PLACE

0038240

Report Period Beginning:

07/01/2006 Ending:

Summary B

06/30/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	2,271	0	0	0	0	0	0	0	0	2,271	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,140)	0	311	0	0	0	0	0	0	0	0	(9,829)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,444	0	0	0	0	0	0	0	0	1,444	34
35	Rent-Equipment & Vehicles	0	0	97	0	0	0	0	0	0	0	0	97	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,140)	0	4,123	0	(6,017)	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):*	(182,588)	0	784	0	0	0	0	0	0	0	0	(181,804)	43
44	TOTAL Special Cost Centers	(182,588)	0	784	0	(181,804)	44							
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,946)	0	59,663	0	(137,283)	45							

Facility Name & ID Number HARRIS PLACE

0038240

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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
<u>PROGRESSIVE HOUSING, INC.</u>	<u>100</u>	<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		<u>SEE ATTACHED RELATED PARTY SCHEDULE</u>		
<u>SEE ATTACHED SCHEDULE 7A</u>						

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	<u>18 BOARD FEES</u>	\$ <u>2,737</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	\$ <u>2,737</u>	\$
2	V	<u>19 PROFESSIONAL FEES</u>	<u>5,045</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>5,045</u>	
3	V	<u>20 LICENSE, DUES</u>	<u>1</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1</u>	
4	V	<u>21 GENERAL OFFICE</u>	<u>1,962</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>1,962</u>	
5	V	<u>23 INSERVICE TRAVEL</u>	<u>295</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>295</u>	
6	V	<u>32 INTEREST</u>	<u>5</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>5</u>	
7	V	<u>32 INTEREST INCOME</u>	<u>(2,600)</u>	<u>PROGRESSIVE HOUSING, INC.</u>	<u>100.00%</u>	<u>(2,600)</u>	
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ <u>7,445</u>			\$ <u>7,445</u>	\$ *

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

Facility Name & ID Number HARRIS PLACE# 0038240Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	17 ADMINISTRATIVE COST	\$	CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	35,876	\$	35,876	15
16	V	19 PROFESSIONAL FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	63		63	16
17	V	20 DUES, FEES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	490		490	17
18	V	22 EMPLOYEE BENEFITS		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	7,757		7,757	18
19	V	23 INSERVICE EDUCATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,151		2,151	19
20	V	24 TRAVEL SEMINAR		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	256		256	20
21	V	26 INSURANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,353		1,353	21
22	V	30 DEPRECIATION		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	2,271		2,271	22
23	V	32 INTEREST		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	299		299	23
24	V	34 RENT		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	1,444		1,444	24
25	V	35 EQUIPMENT RENTAL		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	97		97	25
26	V	5 UTILITIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	779		779	26
27	V	6 MAINTENANCE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	467		467	27
28	V	43 NONALLOWABLE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	784		784	28
29	V	32 MISC INCOME		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	12		12	29
30	V	3 HOUSEKEEPING		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	240		240	30
31	V	21 OFFICE		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	5,299		5,299	31
32	V	10 NURSING SUPPLIES		CENTER FOR RESIDENTIAL MANAGEMENT	PARENT CO.	25		25	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			59,663	\$	* 59,663	39

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

Facility Name & ID Number HARRIS PLACE # 0038240 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	RONALD SCHROEDER	SECRETARY	BOARD MEMBE	NONE	10,218	3HRS/MTG	1.00	DIR. FEES	\$ 582	L18, C8	1
2	SHAWN JEFFERS	CHAIRMAN	BOARD MEMBE	NONE	10,218	3HRS/MTG	1.00	DIR. FEES	582	L18, C8	2
3	EDWARD CHILDERS	VICE CHAIRMAN	BOARD MEMBE	NONE	10,218	3HRS/MTG	1.00	DIR. FEES	582	L18, C8	3
4	ROBERT BAUER	DIRECTOR	BOARD MEMBE	NONE	4,541	3HRS/MTG	1.00	DIR. FEES	259	L18, C8	4
5	CORA FLOTA	DIRECTOR	BOARD MEMBE	NONE	4,542	3HRS/MTG	1.00	DIR. FEES	258	L18, C8	5
6	ORLAND BAUER	TREASURER	BOARD MEMBE	NONE	8,326	3HRS/MTG	1.00	DIR. FEES	474	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,737		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: 07/01/2006

Ending: 6/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PROGRESSIVE HOUSING, INC.
 Street Address 2020 W. WARMEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61614
 Phone Number (309)685-0595
 Fax Number (309)685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	BOARD FEES	NUMBER OF BEDS	297	18	\$ 50,800	\$ 16	\$ 2,737	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	297	18	93,649	16	5,045	2
3	20	LICENSE, DUES	NUMBER OF BEDS	297	18	5	16	1	3
4	21	GENERAL OFFICE	NUMBER OF BEDS	297	18	36,417	16	1,962	4
5	23	INSERVICE TRAVEL	NUMBER OF BEDS	297	18	5,485	16	295	5
6	32	INTEREST	NUMBER OF BEDS	297	18	100	16	5	6
7	32	INTEREST INCOME	NUMBER OF BEDS	297	18	(48,268)	16	(2,600)	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					\$ 138,188	\$	\$ 7,445	25

Facility Name & ID Number HARRIS PLACE

0038240 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CENTER FOR RESIDENTIAL MANAGEMENT
 Street Address 2020 W. WAR MEMORIAL DR. SUITE 103
 City / State / Zip Code PEORIA, IL. 61617
 Phone Number (309-685-0595
 Fax Number (309-685-8463

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE COST	NUMBER OF BEDS	297	18	\$ 665,960	\$ 665,960	16	\$ 35,876	1
2	19	PROFESSIONAL FEES	NUMBER OF BEDS	297	18	1,173		16	63	2
3	20	DUES, FEES	NUMBER OF BEDS	297	18	9,102		16	490	3
4	22	EMPLOYEE BENEFITS	NUMBER OF BEDS	297	18	143,996		16	7,757	4
5	23	INSERVICE EDUCATION	NUMBER OF BEDS	297	18	39,936		16	2,151	5
6	24	TRAVEL SEMINAR	NUMBER OF BEDS	297	18	4,744		16	256	6
7	26	INSURANCE	NUMBER OF BEDS	297	18	25,108		16	1,353	7
8	30	DEPRECIATION	NUMBER OF BEDS	297	18	42,150		16	2,271	8
9	32	INTEREST	NUMBER OF BEDS	297	18	5,547		16	299	9
10	34	RENT	NUMBER OF BEDS	297	18	26,806		16	1,444	10
11	35	EQUIPMENT RENTAL	NUMBER OF BEDS	297	18	1,795		16	97	11
12	5	UTILITIES	NUMBER OF BEDS	297	18	14,451		16	779	12
13	6	MAINTENANCE	NUMBER OF BEDS	297	18	8,673		16	467	13
14	43	NONALLOWABLE	NUMBER OF BEDS	297	18	14,551		16	784	14
15	32	MISC INCOME	NUMBER OF BEDS	297	18	228		16	12	15
16	3	HOUSEKEEPING	NUMBER OF BEDS	297	18	4,446		16	240	16
17	21	OFFICE	NUMBER OF BEDS	297	18	98,367		16	5,299	17
18	10	NURSING SUPPLIES	NUMBER OF BEDS	297	18	460		16	25	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,107,493	\$ 665,960		\$ 59,663	25

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	IL. HEALTH FAC AUTH. BOND	X	FACILITY ACQUISITION	VARIES	03/09/06	\$ 692,503	\$ 692,503	08/15/26	6.7500	\$ 49,355	1									
2	BANTERRA BANK	X	VAN PURCHASE	\$444.00	09/30/05	14,414	6,391	09/30/08	6.7500	689	2									
3											3									
4											4									
5											5									
Working Capital																				
6			OFFSET INTERST INCOME/ NONALLOWABLE INT.							(10,015)	6									
7			MISC./PARENT ALLOCATION							299	7									
8											8									
9	TOTAL Facility Related			\$444.00		\$ 706,917	\$ 698,894			\$ 40,328	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 706,917	\$ 698,894			\$ 40,328	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.)

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HARRIS PLACE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0038240

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>N/A</u>	_____	\$ _____	\$ _____
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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number HARRIS PLACE

0038240 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,100 B. General Construction Type: Exterior brick/vinyl siding Frame WOOD Number of Stories ONE

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

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

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

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

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

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

1. Total Amount Incurred: 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	<u>RESIDENT CARE</u>	<u>47,250</u>	<u>1999</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	47,250		\$ 20,000	3

Facility Name & ID Number HARRIS PLACE

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		\$ 152,083	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		1,237	10
11		DRIVE REPAVING		2004	1,498	100	15	100		291	11
12		BATHROOM CARPET		2006	945	63	15	63		68	12
13		CARPETING		2006	1,558	104	15	104		104	13
14		BATHROOM TILE		2006	1,119	68	15	68		69	14
15		BATHROOM TOILETS		2006	1,026	57	15	57		57	15
16		BATHROOM REMODEL		2006	5,100	227	15	227		227	16
17		BATHROOM REMODEL		2006	3,043	118	15	118		118	17
18		BATHROOM REMODEL		2007	3,355	93	15	93		93	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:

07/01/2006

Ending:

06/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 749,827	\$ 19,226		\$ 19,226	\$	\$ 154,347	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: 07/01/2006 Ending: 06/30/2007

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	\$ 19,344	\$ 2,100	\$ 2,100	\$	5-10YRS	\$ 11,525	71
72	Current Year Purchases	2,771	63	63		10	63	72
73	Fully Depreciated Assets	2,186	42	42		5	2,186	73
74	ALLOCATED FROM PARENT		2,271	2,271				74
75	TOTALS	\$ 24,301	\$ 4,476	\$ 4,476	\$		\$ 13,774	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	REPAIR TO DODGE VAN	2004	\$ 724	\$ 145	\$ 145	\$		\$ 471	76
77	FACILITY USE	2005 DODGE VAN	2005	14,613	2,922	2,922			5,358	77
78	FACILITY USE	96 DODGE VAN	2002		292	292				78
79										79
80	TOTALS			\$ 15,337	\$ 3,359	\$ 3,359	\$		\$ 5,829	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)	\$ 809,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 27,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,061	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)	\$ 173,950	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: 07/01/2006

Ending: 06/30/2007

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 6A				1,444			5
6					_____			6
7	TOTAL				\$ 1,444			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: _____ *

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: \$ 647

Description: SEE SCH 6A, 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		60		60
3	Classroom Wages (a)		686		686
4	Clinical Wages (b)		1,545		1,545
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,291	\$	\$ 2,291
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,291		

C. CONTRACTUAL INCOME

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

\$ 3,100

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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# 0038240Report Period Beginning: 07/01/2006

Ending:

06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2007

(last day of reporting year)

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	\$ 400	\$	1
2	Cash-Patient Deposits	3,212		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,530)	185,078		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67		6
7	Other Prepaid Expenses	152		7
8	Accounts Receivable (owners or related parties)	1,337,910		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,526,819	\$	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	19,827		15
16	Equipment, at Historical Cost	39,638		16
17	Accumulated Depreciation (book methods)	(173,950)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	122,275		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LOAN COST	17,986		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 775,776	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,302,595	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 89,102	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,212		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,734		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,432		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)	\$ 123,480	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,391		39
40	Mortgage Payable	692,503		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	DEFERRED INCOME BONDS	27,806		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 726,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 850,180	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,452,415	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,302,595	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,238,600	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,238,600	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	213,815	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)	\$ 213,815	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)	\$ 1,452,415	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HARRIS PLACE

0038240

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 652,703	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 652,703	3
B. Ancillary Revenue			
4	Day Care	181,804	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 181,804	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,100	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)	\$ 3,100	23
D. Non-Operating Revenue			
24	Contributions	93	24
25	Interest and Other Investment Income***	10,010	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,103	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 847,710	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	71,839	31
32	Health Care	188,894	32
33	General Administration	72,445	33
B. Capital Expense			
34	Ownership	75,497	34
C. Ancillary Expense			
35	Special Cost Centers	181,804	35
36	Provider Participation Fee	43,416	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 633,895	40
41	Income before Income Taxes (line 30 minus line 40)**	213,815	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 213,815	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: **07/01/2006**

Ending:

06/30/2007

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				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees	260	260	2,231	8.58	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	1,633	1,777	14,710	8.28	15
16	Dishwashers				16	
17	Maintenance Workers	784	804	9,541	11.87	17
18	Housekeepers				18	
19	Laundry				19	
20	Administrator	112	138	5,419	39.27	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)	843	872	12,582	14.43	28
29	Resident Services Coordinator	1,143	1,171	25,448	21.73	29
30	Habilitation Aides (DD Homes)	14,363	15,216	130,547	8.58	30
31	Medical Records				31	
32	Other Health Care(specify)				32	
33	Other(specify)				33	
34	TOTAL (lines 1 - 33)	19,138	20,238	\$ 200,478 *	\$ 9.91	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	24	\$ 1,792	L1, C3	35
36	Medical Director	MONTHLY	660	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	100	2,505	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	330	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	10	542	L12, C3	45
46	Other(specify)				46
47	PSYCHOLOGICAL	83	5,576	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	225	\$ 11,405		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
JOHN MIRECKI	ADMINISTRATOR	0	\$ 5,419	Workers' Compensation Insurance	\$ 1,278	IDPH License Fee	\$		
				Unemployment Compensation Insurance	5,792	Advertising: Employee Recruitment	1,879		
				FICA Taxes	17,796	Health Care Worker Background Check	70		
				Employee Health Insurance	11,697	(Indicate # of checks performed <u>7</u>)			
				Employee Meals	5,760	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE	91		
				EMPLOYEE MORAL	1,262	MISCELLANEOUS DUES & FEES	458		
				EMPLOYEE PHYSICALS	80	ADMINISTRATOR LICENSE	19		
						IHCA DUES	472		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 5,419			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,989	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)					
N/A			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
JONES DAY	LEGAL		147	N/A					
LAWRENCE MANSON	LEGAL		767						
KRIEG, DEVAULT	LEGAL		1,223						
HEINOLD-BANWART	ACCOUNTING		2,889						
HEINOLD-BANWART	ACCOUNTING		63				In-State Travel		
SCHULER,ROCHE,ZWIRNER	LEGAL		19				IHCA COVENTION	146	
PERSONNEL PLANNERS, INC UC	CONSULTATION		60				BEST PRACTICES LISLE	98	
							MISC SEMINARS	193	
							Seminar Expense		
							CPR	260	
							WILLOBROOK-UNFORGOTTEN	101	
							COACHING	46	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,168	TOTAL					
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 844

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HARRIS PLACE

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? YES
If YES, give association name and amount. IHCA \$472
- (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? What was the average life used for new equipment added during this period? 5-15YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 379 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. \$ 43,416
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. \$ 5,760 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? 84
- 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? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: 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 of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, 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.