

		FOR BHF USE					

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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: 0035741

Facility Name: LaHarpe-Davier Health Care Center

Address: 101 North B Street, PO Box #547 LaHarpe 61450
 Number City Zip Code

County: Hancock

Telephone Number: 217-659-3222 Fax # 217-659-3017

HFS ID Number: 37-0619841002

Date of Initial License for Current Owners: 07/21/1922

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>501c3</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: James G. Hull **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/05 to 09/30/06 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>James G. Hull, C.P.A.</u> <u>Vice President</u>	
	(Firm Name & Address) <u>WDM Computer Services, Inc.</u> <u>1900 Harrison, Quincy, IL 62301</u>	
	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	
	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 LaHarpe-Davier Health Care Center

0035741 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	16,425	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	7,175	5,984		13,159
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	7,175	5,984		13,159

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.12%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
n/a

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 10/01/1977

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/06 Fiscal Year: 09/30/06

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

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/05 Ending: 09/30/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	103,672	2,920	4,392	110,984		110,984	(965)	110,019		1
2	Food Purchase		82,818		82,818		82,818	(6,959)	75,859		2
3	Housekeeping	44,999	3,542		48,541		48,541	(10,694)	37,847		3
4	Laundry	3,231	2,941	10,028	16,200		16,200		16,200		4
5	Heat and Other Utilities			57,255	57,255		57,255	(12,614)	44,641		5
6	Maintenance	24,324	2,969	33,033	60,326	55	60,381	(13,291)	47,090		6
7	Other (specify):*			10	10		10	(10)			7
8	TOTAL General Services	176,226	95,190	104,718	376,134	55	376,189	(44,533)	331,656		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	466,123	33,804	6,269	506,196		506,196	(73)	506,123		10
10a	Therapy			1,205	1,205		1,205		1,205		10a
11	Activities	5,607	1,277	2,167	9,051	(320)	8,731		8,731		11
12	Social Services	16,093		1,987	18,080	(140)	17,940		17,940		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	487,823	35,081	23,628	546,532	(460)	546,072	(73)	545,999		16
	C. General Administration										
17	Administrative	44,894			44,894		44,894		44,894		17
18	Directors Fees										18
19	Professional Services			21,567	21,567		21,567		21,567		19
20	Dues, Fees, Subscriptions & Promotions			9,242	9,242	(246)	8,996	(2,276)	6,720		20
21	Clerical & General Office Expenses	23,775	4,482	9,711	37,968	156	38,124		38,124		21
22	Employee Benefits & Payroll Taxes			84,778	84,778		84,778		84,778		22
23	Inservice Training & Education			80	80	140	220		220		23
24	Travel and Seminar			335	335		335		335		24
25	Other Admin. Staff Transportation		1,427		1,427		1,427		1,427		25
26	Insurance-Prop.Liab.Malpractice			58,054	58,054		58,054		58,054		26
27	Other (specify):*			288	288		288		288		27
28	TOTAL General Administration	68,669	5,909	184,055	258,633	50	258,683	(2,276)	256,407		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	732,718	136,180	312,401	1,181,299	(355)	1,180,944	(46,882)	1,134,062		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 LaHarpe-Davier Health Care Center #0035741 Report Period Beginning: 10/01/05 Ending: 09/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			36,204	36,204	36,204	(769)	35,435			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						(2,372)	(2,372)			32
33	Real Estate Taxes			34,016	34,016	34,016		34,016			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			318	318	318		318			35
36	Other (specify):*										36
37	TOTAL Ownership			70,538	70,538	70,538	(3,141)	67,397			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		100		100	100		100			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			24,638	24,638	24,638		24,638			42
43	Other (specify):*			10,797	10,797	11,152	(11,149)	3			43
44	TOTAL Special Cost Centers		100	35,435	35,535	35,890	(11,149)	24,741			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	732,718	136,280	418,374	1,287,372	1,287,372	(61,172)	1,226,200			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 LaHarpe-Davier Health Care Center

0035741

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(965)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(73)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1	30		9
10	Interest and Other Investment Income	(2,372)	32		10
11	Discounts, Allowances, Rebates & Refunds	(48)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	7		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(114)	43		17
18	Fines and Penalties	(10,515)	43		18
19	Entertainment				19
20	Contributions	(320)	43		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	(2,276)	20		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	(44,480)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (61,172)		\$	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))	\$ (61,172)		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

LaHarpe-Davier Health Care Center

ID# 0035741

Report Period Beginning: 10/01/05

Ending: 09/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Exp.	\$ (200)	43	1
2	Independent Living Utilities Cost	(7,701)	5	2
3	Independent Living Maintenance Cost	(8,114)	6	3
4	Independent Living Housekeeping Cost	(6,529)	3	4
5	Independent Living Meal Costs	(6,911)	2	5
6	Clinic Maintenance Costs	(5,177)	6	6
7	Clinic Housekeeping Costs	(4,165)	3	7
8	Clinic Utilities Costs	(4,913)	5	8
9	Non-Care Related Deprec.	(770)	30	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	(44,480)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaHarpe-Davier Health Care Center

0035741

Report Period Beginning:

10/01/05

Ending:

09/30/06

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	(965)	0	0	0	0	0	0	0	0	0	0	(965)	1
2	Food Purchase	(6,959)	0	0	0	0	0	0	0	0	0	0	(6,959)	2
3	Housekeeping	(10,694)	0	0	0	0	0	0	0	0	0	0	(10,694)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,614)	0	0	0	0	0	0	0	0	0	0	(12,614)	5
6	Maintenance	(13,291)	0	0	0	0	0	0	0	0	0	0	(13,291)	6
7	Other (specify):*	(10)	0	0	0	0	0	0	0	0	0	0	(10)	7
8	TOTAL General Services	(44,533)	0	0	0	0	0	0	0	0	0	0	(44,533)	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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	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	(2,276)	0	0	0	0	0	0	0	0	0	0	(2,276)	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	(2,276)	0	0	0	0	0	0	0	0	0	0	(2,276)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,882)	0	0	0	0	0	0	0	0	0	0	(46,882)	29

STATE OF ILLINOIS

Facility Name & ID Number LaHarpe-Davier Health Care Center

0035741

Report Period Beginning:

10/01/05 Ending:

Summary B

09/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(769)	0	0	0	0	0	0	0	0	0	0	(769)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,372)	0	0	0	0	0	0	0	0	0	0	(2,372)	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	(3,141)	0	(3,141)	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):*	(11,149)	0	0	0	0	0	0	0	0	0	0	(11,149)	43
44	TOTAL Special Cost Centers	(11,149)	0	(11,149)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(61,172)	0	(61,172)	45									

Facility Name & ID Number LaHarpe-Davier Health Care Center

0035741

Report Period Beginning:

10/01/05

Ending:

09/30/06

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/05 Ending: 09/30/06

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 LaHarpe-Davier Health Care Center

0035741

Report Period Beginning: 10/01/05

Ending: 09/30/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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	TOTALS				\$	\$		\$	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	GMAC		X	Construction Costs	n/a	04/07/76	\$ 1,146,000	\$ 559,698	04/07/16	5.0000	\$ 31,825	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	First State Bank of Western Illinois		X	Cash Flow	Interst	Various	Various		Various	Various	2,191	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,146,000	\$ 559,698			\$ 34,016	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,146,000	\$ 559,698			\$ 34,016	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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:** 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 LaHarpe-Davier Health Care Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0035741

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 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	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 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 LaHarpe-Davier Health Care Center

0035741 Report Period Beginning:

10/01/05 Ending:

09/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 3

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare		1992-1976	\$ 34,133	1
2	Laundry		1977	5,911	2
3	TOTALS			\$ 40,044	3

Facility Name & ID Number LaHarpe-Davier Health Care Center

0035741

Report Period Beginning:

10/01/05

Ending:

09/30/06

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	49			1977	\$ 1,606,424	\$ 22,265	various	\$ 22,265	\$ (0)	\$ 1,375,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SINK UNIT		1979	860					856	9
10		NEW ROOF		1980	6,278					6,123	10
11		Patio/Sidewalk		1983	986					986	11
12		ROO REPAIRS, PHONE EQUIP		1984	11,617					11,617	12
13		ROOF, AC REPAIRS, WATER HEATER		1985	7,816					7,718	13
14		WATER HEATER		1986							14
15		REMODELING, ROOF REPAIRS		1987	31,941	1,063	Various	1,065	2	20,376	15
16		WINDOW REPLACEMENT		1988	715	36	20	36		670	16
17		DOORS, NURSING OFFICE ELEVATOR REPAIRS		1990	12,074	87	Various	87		11,304	17
18		NEW ROOF, DOOR & ALARM, AC TURF		1991	59,681	245	Various	245		59,277	18
19		MASONARY REPAIR, COMPRESSOR		1992	9,276	402	Various	402		5,700	19
20		NEW ROOF		1993	19,000		10			19,000	20
21		CARPET,ALARM, COMPRESSOR		1994	10,165	213	Various	213		9,205	21
22		WATER SOFTNER, SIDEWALKS, BLINDS		1995	4,716	148	Various	148		4,134	22
23		WINDOW GLASS		1996	1,428	72	20	71	(1)	749	23
24		FIRE ALARM		1997	3,340	334	10	334		3,090	24
25		REPLACEMENT DOOR		1996	1,096	55	20	55		540	25
26		BUILDING CARPET		1997	1,489		6			1,489	26
27		FIXED EQUIPMENT		1998	11,452	844	Various	844		9,102	27
28		LAND IMPROVEMENT		1998	575	38	15	38		322	28
29		GAZEBO		2000	4,895	245	20	245		1,652	29
30		BOILER REPAIRS		2000	1,784	119	15	119		793	30
31		AIR CONDITIONER		2000	550		5			532	31
32		PATIO ROOF AWNING		2001	1,904	127	15	127		656	32
33		DAY CARE SIDEWALK		1999	800	53	15	53		377	33
34		SIDEWALK		2002	2,975	198	15	198		845	34
35		KID CARE REMODELING		2002	1,860	124	180	124		548	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 LaHarpe-Davier Health Care Center

0035741

Report Period Beginning:

10/01/05

Ending:

09/30/06

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)	\$ 1,815,697	\$ 26,668		\$ 26,669	\$ 1	\$ 1,553,582	70

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

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0035741 Report Period Beginning: 10/01/05 Ending: 09/30/06

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	\$ 86,677	\$ 8,766	\$ 8,766	\$ 0	10	\$ 55,156	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	211,867				10	210,245	73
74								74
75	TOTALS	\$ 298,544	\$ 8,766	\$ 8,766	\$ 0		\$ 265,401	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	Nursing Home Related	94 Ford Pick-up	1996	\$ 10,000	\$	\$	\$	4	\$ 10,000	76
77	Nursing Home Related	90 Ford Van	1999	2,000				4	2,000	77
78										78
79										79
80	TOTALS			\$ 12,000	\$	\$	\$		\$ 12,000	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)	\$ 2,166,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,434	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,435	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,830,983	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	Clinic	\$ 22,629	\$ 770	\$ 22,461	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 22,629	\$ 770	\$ 22,461	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.

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					_____			5
6					_____			6
7	TOTAL				\$ _____			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: _____*

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: \$ 318

Description: Copier Rental

(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

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 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	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 LaHarpe-Davier Health Care Center# 0035741Report Period Beginning: 10/01/05

Ending:

09/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/06

(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	\$ 80,052	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>FIFO</u>)	103,400		3
4	Supply Inventory (priced at)	2,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,494		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 200,446	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	91,985		13
14	Buildings, at Historical Cost	1,758,599		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	390,271		16
17	Accumulated Depreciation (book methods)	(1,853,442)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Rounding</u>	1		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 387,414	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 587,860	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,062	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,519		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,198)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,321		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Clinic Pymts Withheld</u>	247		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 97,951	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	559,698		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Accrued Fees/Fines Pyables</u>	21,775		43
44	<u>Rounding</u>	(1)		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 581,472	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 679,423	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (91,563)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 587,860	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (88,711)	1
2	Restatements (describe):		2
3	<u>Prior Year Audit Adjustments</u>	(32,998)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (121,709)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	30,146	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)	\$ 30,146	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)	\$ (91,563)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LaHarpe-Davier Health Care Center# 0035741Report Period Beginning: 10/01/05Ending: 09/30/06**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	\$ 1,033,313	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,033,313	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	965	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	73	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)	\$ 1,038	23
D. Non-Operating Revenue			
24	Contributions	193,343	24
25	Interest and Other Investment Income***	2,372	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 195,715	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activities Program Income	1,620	28
28a	See List Attached	85,832	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 87,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,317,518	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	376,134	31
32	Health Care	546,532	32
33	General Administration	258,633	33
B. Capital Expense			
34	Ownership	70,538	34
C. Ancillary Expense			
35	Special Cost Centers	10,897	35
36	Provider Participation Fee	24,638	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,287,372	40
41	Income before Income Taxes (line 30 minus line 40)**	30,146	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,146	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 LaHarpe-Davier Health Care Center

0035741

Report Period Beginning: 10/01/05

Ending: 09/30/06

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	1,927	2,007	\$ 36,716	\$ 18.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,111	1,197	20,796	17.37	3
4	Licensed Practical Nurses	9,177	9,765	141,012	14.44	4
5	CNAs & Orderlies	26,831	28,361	246,414	8.69	5
6	CNA Trainees	1,799	1,856	12,286	6.62	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	545	625	5,607	8.97	9
10	Activity Assistants					10
11	Social Service Workers	1,391	1,543	16,093	10.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,000	2,080	29,120	14.00	14
15	Cook Helpers/Assistants	6,085	6,250	47,214	7.55	15
16	Dishwashers	3,528	3,731	27,338	7.33	16
17	Maintenance Workers	1,543	1,853	24,324	13.13	17
18	Housekeepers	6,326	6,597	44,999	6.82	18
19	Laundry	147	171	3,231	18.89	19
20	Administrator	1,862	2,097	44,894	21.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,816	1,970	23,775	12.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS Coord.	417	417	8,899	21.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	66,505	70,520	\$ 732,718 *	\$ 10.39	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	96	\$ 4,392	1-3	35
36	Medical Director	Contract	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	674	10-3	39
40	Physical Therapy Consultant	10	1,110	10a-3	40
41	Occupational Therapy Consultant	1	95	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,847	11-3	44
45	Social Service Consultant	26	1,847	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	159	\$ 21,965		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	121	\$ 4,780	10-3	50
51	Licensed Practical Nurses	23	815	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	143	\$ 5,595		53

Facility Name & ID Number LaHarpe-Davier Health Care Center

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. II Hospital Association \$857.90
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,364 Line 10-2
- (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. _____
- (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. \$ 24,638
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? Yes 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? Yes 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 965
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 90
d. Have vehicle usage logs been maintained? N/a
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? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Bennett & Middendorf The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet finalized
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

LaHarpe Davier Healthcare Center, Inc.
#0035741
10/01/05 to 09/30/06

Schedule V, Line 6, Column 3

Dietary Repairs/Maint	\$1,083.76
Laundry Repairs/Maint	883.43
Plant/Operation Outside Services	\$10,287.39
Building Repairs	\$2,619.94
Equipment Repairs	\$10,895.73
Ground Repairs	\$92.75
Rent Exp.	\$660.00
Cable TV	\$530.74
Elevator Maintenance	\$1,875.53
Refuse Expense	\$4,251.87
Computer Repairs	\$611.56
Muzak	\$55.00
	<u>\$33,087.70</u>

Schedule V, Line 21, Column 3

Telephone Expense	\$6,164.49
Data Processing In-House	\$239.40
Data Processing Support Costs	\$3,307.02
	<u>\$9,710.91</u>

Schedule V, Line 25, Column 2

Auto Repairs/Maint.	\$0.00
Auto Gas/Oil	\$1,427.26
Employee Mileage Reimbursement	\$0.00
	<u>\$1,427.26</u>

Schedule V, Line 43, Column 4

Misc Expense	\$10,794.33
Contributions	\$320.00
Rounding	\$3.00
Bank Card Fee (Reclassified)	<u>\$25.00</u>
	<u>\$11,152.33</u>

Schedule XX, Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Personal Purchases Income	\$0.00
W/C Reimbursement	\$0.00
Independent Living	\$74,300.00
Guest Room Rental	\$0.00
Clinic Rental Income	\$11,000.00
House Rental Income	\$0.00
Rebates	\$47.59
Gain on sale of Assets	\$500.00
Miscellaneous Income	-\$16.75
Rounding	\$1.00
	<u>\$85,821.84</u>

Schedule XIX, Section F

MEDDP Membership	\$175.00
IPDH Dues	\$995.00
Creative Software License	\$579.00
IL Charity Bureau Fund	\$15.00
LaHarpe Park District	\$50.00
First Bank Safe Deposit Box Fee	\$15.00
Office of the Attorney General Fee	\$100.00
IL Department of Finance	\$75.00
IL Secretary of State	\$156.00
	<u>\$2,160.00</u>

LaHarpe Davier Healthcare Center, Inc.

#0035741

10/01/05 to 09/30/06

Board Members

Carl Lee
401 S. 2nd St.
LaHarpe, IL 61450

John Rodeffer
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Dallas City, IL 62330

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LaHarpe Davier Healthcare Center, Inc.
#0035741
10/01/05 to 09/30/06

Reclassifications

1. Reclass \$55.00 for storage space rent out of Dues and cost it to Maint. Expense.
2. Reclass \$320.00 for Donations to Laharpe Senior Center out of Activity Expense and cost it to Charitable donations.
3. Reclass \$140.00 for Social Service Training videos out of Social service expenses and cost it to In-Service Training Expense.
4. Reclass \$35.00 for Bancard fee out of License Fee and cost it to Misc. Expense as a bank fee.
5. Reclass \$156.00 for Postage out of Background checks and cost it to Postage

Allocation of Independent Living/Clinic Revenue
 Page 5A Adjustments

Meals Served

Nursing Home	33852	91.66%
Independent Living	3082	8.34%
	36934	100.00%

Raw Food Cost	\$82,818.00
Nursing Home	\$75,907.16
Independent Living	\$6,910.84

Square Feet

Nursing Home	23188	77.97%
Independent Living	4000	13.45%
Clinic	2552	8.58%
	29740	100.00%

Utilities Costs	\$57,255.00
Housekeeping Costs	\$48,541.00
Maintenance Costs	\$60,326.00

	Utilities	Hskg	Maint.
Independent Living	\$7,700.74	\$6,528.72	\$8,113.79
Clinic	\$4,913.07	\$4,165.32	\$5,176.60