



Facility Name & ID Number LaHarpe-Davier Health Care Center

# 0035741 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

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 N/A

	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	9,147	4,452		13,599
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	9,147	4,452		13,599

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.79%

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)  
Independent Living, Meals on Wheels, Clinic

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 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/07 Fiscal Year: 09/30/07

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

Facility Name & ID Number LaHarpe-Davies Health Care Center # 0035741 Report Period Beginning: 10/1/2006 Ending: 9/30/2007

**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
<b>1</b>	<b>A. General Services</b>										
1	Dietary	112,288	4,290	1,112	117,690		117,690	(3,068)	114,622		1
2	Food Purchase		58,628		58,628		58,628	(2,719)	55,909		2
3	Housekeeping	51,614	9,020		60,634		60,634	(1,581)	59,053		3
4	Laundry		5,649	3,216	8,865		8,865	(1,192)	7,673		4
5	Heat and Other Utilities			46,307	46,307		46,307	(10,202)	36,105		5
6	Maintenance	17,609	6,129	24,207	47,945		47,945	(10,563)	37,382		6
7	Other (specify):* <b>Fringe Ben. Alloc.</b>			1,295	1,295		1,295		1,295		7
<b>8</b>	<b>TOTAL General Services</b>	<b>181,511</b>	<b>83,716</b>	<b>76,137</b>	<b>341,364</b>		<b>341,364</b>	<b>(29,325)</b>	<b>312,039</b>		<b>8</b>
<b>9</b>	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	450,352	17,568	4,327	472,247		472,247		472,247		10
10a	Therapy		214	7,600	7,814		7,814		7,814		10a
11	Activities	22,275	1,054	289	23,618		23,618		23,618		11
12	Social Services	28,645	4		28,649		28,649		28,649		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>501,272</b>	<b>18,840</b>	<b>23,216</b>	<b>543,328</b>		<b>543,328</b>		<b>543,328</b>		<b>16</b>
<b>17</b>	<b>C. General Administration</b>										
17	Administrative	38,037			38,037		38,037		38,037		17
18	Directors Fees										18
19	Professional Services			9,996	9,996		9,996		9,996		19
20	Dues, Fees, Subscriptions & Promotions			7,111	7,111		7,111		7,111		20
21	Clerical & General Office Expenses	27,295	3,496	8,255	39,046		39,046		39,046		21
22	Employee Benefits & Payroll Taxes			91,045	91,045		91,045		91,045		22
23	Inservice Training & Education			626	626		626		626		23
24	Travel and Seminar			1,073	1,073		1,073		1,073		24
25	Other Admin. Staff Transportation			719	719		719		719		25
26	Insurance-Prop.Liab.Malpractice			24,681	24,681		24,681		24,681		26
27	Other (specify):*										27
<b>28</b>	<b>TOTAL General Administration</b>	<b>65,332</b>	<b>3,496</b>	<b>143,506</b>	<b>212,334</b>		<b>212,334</b>		<b>212,334</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>748,115</b>	<b>106,052</b>	<b>242,859</b>	<b>1,097,026</b>		<b>1,097,026</b>	<b>(29,325)</b>	<b>1,067,701</b>		<b>29</b>

\*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:

10/1/2006

Ending:

9/30/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
30	D. Ownership											
	Depreciation			35,711	35,711		35,711		35,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			144	144		144	(28)	116			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,974	2,974		2,974		2,974			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			38,829	38,829		38,829	(28)	38,801			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,407		1,407		1,407		1,407			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,638	24,638		24,638		24,638			42
43	Other (specify):* <b>Non-allow. Cost</b>		222	4,080	4,302		4,302	(4,302)				43
44	<b>TOTAL Special Cost Centers</b>		1,629	28,718	30,347		30,347	(4,302)	26,045			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	748,115	107,681	310,406	1,166,202		1,166,202	(33,655)	1,132,547			45

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

\*\*See schedule of adjustments attached at end of cost report.

Facility Name & ID Number LaHarpe-Davier Health Care Center

# 0035741

Report Period Beginning: 10/1/2006

Ending: 9/30/2007

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				3
4	Non-Patient Meals	(1,191)	2		4
5	Telephone, TV & Radio in Resident Rooms	(498)	43		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	(28)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(389)	43		18
19	Entertainment				19
20	Contributions	(23)	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	(3,174)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(28,227)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (33,655)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (33,655)</b>		<b>37</b>

\*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.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

## LaHarpe-Davier Health Care Center

ID# 0035741

Report Period Beginning: 10/1/2006

Ending: 9/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	\$ (93)	43	1
2	Independent Living Meal Cost	(1,528)	2	2
3	Independent Living Housekeeping Cost	(1,581)	3	3
4	Independent Living Utilities Cost	(6,228)	5	4
5	Independent Living Maintenance Cost	(6,449)	6	5
6	Independent Living Laundry Cost	(1,192)	4	6
7	Clinic Utilities Cost	(3,974)	5	7
8	Clinic Maintenance Cost	(4,114)	6	8
9	Independent Living Dietary Cost	(3,068)	1	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	<b>Total</b>	(28,227)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaHarpe-Davier Health Care Center# 0035741

Report Period Beginning:

10/1/2006

Ending:

9/30/2007

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)	
	<b>A. General Services</b>													
1	Dietary	(3,068)	0	0	0	0	0	0	0	0	0	0	(3,068)	1
2	Food Purchase	(2,719)	0	0	0	0	0	0	0	0	0	0	(2,719)	2
3	Housekeeping	(1,581)	0	0	0	0	0	0	0	0	0	0	(1,581)	3
4	Laundry	(1,192)	0	0	0	0	0	0	0	0	0	0	(1,192)	4
5	Heat and Other Utilities	(10,202)	0	0	0	0	0	0	0	0	0	0	(10,202)	5
6	Maintenance	(10,563)	0	0	0	0	0	0	0	0	0	0	(10,563)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(29,325)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,325)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(29,325)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,325)</b>	<b>29</b>



**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
N/A						

**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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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	See Attached Schedule 7A for list of Board of Directors								\$		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: 10/1/2006

Ending: 3/30/2007

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	GMAC		X	Construction Costs		04/07/76	\$ 1,146,000	\$ 559,698	04/07/16	0.0500	\$	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	First State Bank of Western											6							
7	Illinois		X	Working Capital	Interest Only	Various			Various	Various		144							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 1,146,000	\$ 559,698			\$	144							
<b>B. Non-Facility Related*</b>																			
10												10							
11							Interest Income Offset					(28)							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(28)							
15	<b>TOTALS (line 9+line14)</b>						\$ 1,146,000	\$ 559,698			\$	116							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* 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.)

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2006		\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6				\$	7
Real Estate Tax History:		<b>N/A-THIS FACILITY IS A NOT-FOR-PROFIT ENTITY AND IS EXEMPT FROM PAYING REAL ESTATE TAXES</b>			
Real Estate Tax Bill for Calendar Year:	2002	8			
	2003	9			
	2004	10			
	2005	11			
	2006	12			
			<b>FOR BHF USE ONLY</b>		
			13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 LaHarpe-Davier Health Care Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0035741

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

**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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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.

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).

Independent Living

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident</u>	<u>31,944</u>	<u>1976</u>	<u>\$ 34,133</u>	1
2	<u>Resident</u>		<u>1977</u>	<u>5,911</u>	2
3	TOTALS	<u>31,944</u>		<u>\$ 40,044</u>	3

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		1977	1977	\$ 1,606,424	\$ 22,265	Various	\$ 22,265	\$	\$ 1,398,186	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/Sidewalks		1983		986					986	11
12	Roof Repairs/Phone Equipment		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	1,065	Various	1,065		21,441	15
16	Window Replacement		1988		715	36	20	36		706	16
17	Doors-Nursing Office, Elevator Repairs		1990		12,074	87	Various	87		11,391	17
18	New Roof, Door & Alarm, AC Turf		1991		59,681	245	Various	245		59,522	18
19	Masonry Repair, Compressor		1992		9,276	402	Various	402		6,102	19
20	New Roof		1993		19,000					19,000	20
21	Carpet, Alarm, Compressor		1994		10,165	213	Various	213		9,418	21
22	Water Softener, Sidewalks, Blinds		1995		4,716	148	Various	148		4,282	22
23	Window Glass		1996		1,428	71	20	71		820	23
24	Fire Alarm		1997		3,340	250	10	250		3,340	24
25	Replacement Door		1996		1,096	55	20	55		595	25
26	Building Carpet		1997		1,489					1,489	26
27	Fixed Equipment		1998		11,452	844	Various	844		9,946	27
28	Land Improvement		1998		575	38	15	38		360	28
29	Gazebo		2000		4,895	245	20	245		1,897	29
30	Boiler Repairs		2000		1,784	119	15	119		912	30
31	Air Conditioner		2000		550		5			532	31
32	Patio Roof Awning		2001		1,904	127	15	127		783	32
33	Day Care Sidewalk		1999		800	53	15	53		430	33
34	Sidewalk		2002		2,975	198	15	198		1,043	34
35	Kid Care Remodeling		2002		1,860	124	15	124		672	35
36											36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

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 Concrete Work	2007	\$ 4,595	\$ 153	15	\$ 153	\$	\$ 153	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)		\$ 1,820,292	\$ 26,738		\$ 26,738	\$	\$ 1,580,320	70

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

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		10	\$ 62,300	71
72	Current Year Purchases	4,143	207	207		10	207	72
73	Fully Depreciated Assets	211,867					211,867	73
74								74
75	TOTALS	\$ 302,687	\$ 8,973	\$ 8,973			\$ 274,374	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	1994 Ford Pick-Up	1996	\$ 10,000				4	\$ 10,000	76
77	Nursing Home Related	1990 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)	\$ 2,175,023	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,711	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,711	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)	\$ 1,866,694	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	\$ 168	\$ 22,629	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 22,629	\$ 168	\$ 22,629	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	<b>TOTAL</b>				\$ _____			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: \$ 2,974 Description: See attached Schedule 14A

(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	<b>TOTAL</b>		\$ _____	\$ _____	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. /2008 \$ \_\_\_\_\_

13. /2009 \$ \_\_\_\_\_

14. /2010 \$ \_\_\_\_\_

\* 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.

**LaHarpe-Davier Health Care Center**

**0035741**

**Period Beginning 10/1/2006**

**Period Ending 9/30/2007**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Copier	767
Storage Facility	293
Water Cooler	25
Medical Equipment	<u>1,889</u>
	<u><u>2,974</u></u>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	269	\$ 4,033	\$	269	\$ 4,033	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		13	198		13	198	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-2, 10a-3	hrs		225	3,369	214	225	3,583	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	PTA Assistants Other (specify): <b>Drugs</b>	39-2					1,407		1,407	13
14	<b>TOTAL</b>			\$	507	\$ 7,600	\$ 1,621	507	\$ 9,221	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 &amp; ID Number LaHarpe-Davier Health Care Center

# 0035741

Report Period Beginning: 10/1/2006

Ending:

9/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2007

(last day of reporting year)

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

	1	2		
	Operating	After Consolidation*		
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 51,814	\$ 51,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A )	158,307	158,307	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,997	2,997	6
7	Other Prepaid Expenses	2,500	2,500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	550	550	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 216,168	\$ 216,168	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,229	40,044	13
14	Buildings, at Historical Cost	1,541,526	1,606,424	14
15	Leasehold Improvements, at Historical Cos	204,424	213,868	15
16	Equipment, at Historical Cost	394,414	314,687	16
17	Accumulated Depreciation (book methods)	(1,889,151)	(1,866,694)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 360,442	\$ 308,329	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 576,610	\$ 524,497	25

	1	2		
	Operating	After Consolidation*		
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 81,306	\$ 81,306	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,240	24,240	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,026	3,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,321	28,321	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule 17A</u>	32,058	32,058	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 168,951	\$ 168,951	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	559,698	559,698	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Accounts Payable-Prior Owner</u>	25,982	25,982	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 585,680	\$ 585,680	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 754,631	\$ 754,631	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (178,021)	\$ (230,134)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 576,610	\$ 524,497	48

\*(See instructions.)

**LaHarpe-Davier Health Care Center**

**0035741**

**Period Beginning 10/1/2006**

**Period Ending 9/30/2007**

**Schedule 17A**

**Other Current Liabilities**

<b>Description</b>	<b>Amount</b>
FICA Withholding	2,282
Federal Withholding	2,285
State Withholding-Iowa	255
State Withholding-Illinois	1,715
Due from Manager	25,653
Life Insurance Withholding	<u>(132)</u>
<b>Other Current Liabilities</b>	<b><u><u>32,058</u></u></b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (91,563)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Prior Year Audit Adjustments</u>	(82)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (91,645)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(86,376)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (86,376)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (178,021)	<b>24</b> *

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

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,028,221	1
2	Discounts and Allowances for all Levels	(4,330)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,023,891	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	1,191	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space	12,000	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 13,191	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,505	24
25	Interest and Other Investment Income***	28	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,533	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Attached Schedule 19A</b>	39,210	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 39,210	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,079,825	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	341,364	31
32	Health Care	543,328	32
33	General Administration	212,334	33
<b>B. Capital Expense</b>			
34	Ownership	38,829	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,709	35
36	Provider Participation Fee	24,638	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	(1)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,166,201	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(86,376)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (86,376)	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.

LaHarpe-Davier Health Care Center  
0035741

Period Beginning 10/1/2006  
Period Ending 9/30/2007

**Schedule XVII, Line 28-Miscellaneous Revenue**

<b>Account</b>	<b>Amount</b>
Forgiveness of Working Capital Debt	7,955
Independent Living Income	26,850
Meals on Wheels Income	<u>4,405</u>
<b>Total Miscellaneous Revenue</b>	<b><u><u>39,210</u></u></b>

Facility Name & ID Number LaHarpe-Davies Health Care Center

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	1,920	1,964	\$ 39,815	\$ 20.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,089	2,102	37,830	18.00	3
4	Licensed Practical Nurses	8,389	8,563	124,019	14.48	4
5	CNAs & Orderlies	24,452	25,408	223,628	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	1,947	22,275	11.44	9
10	Activity Assistants					10
11	Social Service Workers	2,001	2,045	28,645	14.01	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,080	29,990	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,530	10,735	82,298	7.67	15
16	Dishwashers					16
17	Maintenance Workers	1,577	1,577	17,609	11.17	17
18	Housekeepers	6,555	6,690	51,614	7.72	18
19	Laundry					19
20	Administrator	1,764	1,846	38,037	20.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,204	2,338	27,295	11.67	23
24	Clerical					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(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	1,439	1,455	25,060	17.22	33
34	TOTAL (lines 1 - 33)	66,895	68,750	\$ 748,115 *	\$ 10.88	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	Monthly \$ 1,112	1-3	35
36	Medical Director	Monthly 11,000	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 250	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,362		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	27 874	10-3	51
52	Certified Nurse Assistants/Aides	140 3,203	10-3	52
53	TOTAL (lines 50 - 52)	167 \$ 4,077		53

**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	Amount	
Janice Fink	Administrator	0	\$ 20,704	Workers' Compensation Insurance	\$ 30,754	IDPH License Fee	\$ 3,865		
Laura Chambers	Administrator	0	17,333	Unemployment Compensation Insurance	8,362	Advertising: Employee Recruitment	769		
				FICA Taxes	50,805	Health Care Worker Background Check			
				Employee Health Insurance		(Indicate # of checks performed)			
				Employee Meals		Worker & Patient Background	64	636	
				Illinois Municipal Retirement Fund (IMRF)*		Misc. License & Permits		626	
				Employee Vision/Dental	53	IHA Dues		901	
				Employee Relations	1,071	Misc. Subscriptions & Dues		314	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
E-Health Data Solutions	Computer Services		\$ 925			\$	Out-of-State Travel	\$	
LTC Solutions	Computer Services		660						
LaHarpe Telephone Company	Computer Services		180						
WDM Data Processing	Computer Services		5,787				In-State Travel	1,043	
Scott Bowles	Legal Services		375						
Scott Bowles	Appraisal Fee		275						
Misc. Vendors	Computer Services		109						
Create Software	Computer Services		1,502				Seminar Expense	30	
Cyber Computer Services	Computer Services		183						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$	Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 1,073	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number LaHarpe-Davier Health Care Center# 0035741Report Period Beginning: 10/1/2006Ending: 9/30/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,630 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. 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. \$ 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? 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? 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  
**See Attached Schedule 23A**
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,191
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 90  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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 service performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.