

Facility Name & ID Number Havana Health Care Center

0046086 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,320</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>78</u>	Intermediate (ICF)	<u>78</u>	<u>28,548</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,868</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,329</u>	<u>2,329</u>	8
9	SNF/PED					9
10	ICF	<u>17,740</u>	<u>7,237</u>		<u>24,977</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,740</u>	<u>7,237</u>	<u>2,329</u>	<u>27,306</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.13%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 03/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/01 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 2,329

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	166,463	34,330		200,793		200,793	4,854	205,647		1
2	Food Purchase		206,454		206,454		206,454	(150,536)	55,918		2
3	Housekeeping	90,864	12,270		103,134		103,134	36	103,170		3
4	Laundry	40,765	9,416		50,181		50,181	2	50,183		4
5	Heat and Other Utilities			120,472	120,472		120,472	503	120,975		5
6	Maintenance	34,803	16,923	21,217	72,943		72,943	2,966	75,909		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,193	1,193		7
8	TOTAL General Services	332,895	279,393	141,689	753,977		753,977	(140,982)	612,995		8
	B. Health Care and Programs										
9	Medical Director			15,500	15,500		15,500		15,500		9
10	Nursing and Medical Records	970,972	59,154	12,015	1,042,141		1,042,141	5,140	1,047,281		10
10a	Therapy	43,504	52	138	43,694		43,694		43,694		10a
11	Activities	37,515	695	121	38,331		38,331		38,331		11
12	Social Services	22,370			22,370		22,370		22,370		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,471	1,471		15
16	TOTAL Health Care and Programs	1,074,361	59,901	27,774	1,162,036		1,162,036	6,611	1,168,647		16
	C. General Administration										
17	Administrative	67,892			67,892		67,892	37,783	105,675		17
18	Directors Fees										18
19	Professional Services			3,016	3,016		3,016	4,264	7,280		19
20	Dues, Fees, Subscriptions & Promotions			7,021	7,021		7,021	1,315	8,336		20
21	Clerical & General Office Expenses	25,363	7,575	9,886	42,824		42,824	47,288	90,112		21
22	Employee Benefits & Payroll Taxes			205,874	205,874		205,874		205,874		22
23	Inservice Training & Education			195	195		195	288	483		23
24	Travel and Seminar							289	289		24
25	Other Admin. Staff Transportation			8,874	8,874		8,874	3,733	12,607		25
26	Insurance-Prop.Liab.Malpractice			21,645	21,645		21,645	227	21,872		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							13,499	13,499		27
28	TOTAL General Administration	93,255	7,575	256,511	357,341		357,341	108,686	466,027		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,500,511	346,869	425,974	2,273,354		2,273,354	(25,685)	2,247,669		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 Havana Health Care Center

#0046086

Report Period Beginning:

1/1/2008

Ending:

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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	
	D. Ownership											
30	Depreciation			65,233	65,233		65,233	26,214	91,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			193,211	193,211		193,211	3,622	196,833			32
33	Real Estate Taxes			86,610	86,610		86,610	693	87,303			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,722	7,722		7,722	591	8,313			35
36	Other (specify):*											36
37	TOTAL Ownership			352,776	352,776		352,776	31,120	383,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,805		70,805		70,805		70,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,802	53,802		53,802		53,802			42
43	Other (specify):* Non-allowable Cost	43,057	533	57,827	101,417		101,417	(101,417)				43
44	TOTAL Special Cost Centers	43,057	71,338	111,629	226,024		226,024	(101,417)	124,607			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,543,568	418,207	890,379	2,852,154		2,852,154	(95,982)	2,756,172			45

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

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	(150,616)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,072)	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	21,048	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(80)	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	(3,727)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,932)	43		24
25	Fund Raising, Advertising and Promotional	(47,971)	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	(18,045)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (234,407)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	138,425	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 138,425		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (95,982)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Havana Health Care Center

ID# 0046086

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,943)	43	1
2	X-Rays-Part A	(5,293)	43	2
3	Resident Flower	(251)	43	3
4	Disallowed Special Events	(148)	43	4
5	Offset of Miscellaneous Income	(3,410)	10&21	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
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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	(18,045)		49

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
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,854	\$ 4,854	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	80	80	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	503	503	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,966	2,966	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,193	1,193	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,424	8,424	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,471	1,471	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	37,783	37,783	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,264	4,264	12
13	V							13
14	Total		\$			\$ 61,576	\$ *	61,576 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,315	\$	1,315	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	47,414		47,414	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	288		288	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	289		289	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,733		3,733	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	227		227	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,499		13,499	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,166		5,166	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,634		3,634	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	693		693	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	591		591	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 76,849	\$ *	76,849	39

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

Facility Name & ID Number

Havana Health Care Center

0046086

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	Mark Petersen	President	Administrative	100.00	1,790,891	1.13	1.89	Salary	37,783	L17, C7	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	\$ 37,783		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 Havana Health Care Center# 0046086 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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 Petersen Health Care, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	27,306	\$ 4,854	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	27,306	80	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	27,306	36	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	27,306	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	27,306	503	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	27,306	2,966	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	27,306	1,193	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	27,306	8,424	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	27,306	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	27,306	1,471	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	27,306	37,783	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	27,306	4,264	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	27,306	1,315	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	27,306	47,414	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	27,306	288	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	27,306	289	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	27,306	3,733	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	27,306	227	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	27,306	13,499	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	27,306	5,166	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	27,306	3,634	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	27,306	693	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	27,306	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	27,306	591	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 138,425	25

Facility Name & ID Number

Havana Health Care Center

0046086

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 2,998,763	12/31/13	Varies	\$ 193,211	1				
2												2				
3							Interest Income Offset				(12)	3				
4							Home Office Allocation-PHC				3,634	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 3,075,000	\$ 2,998,763			\$ 196,833	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 3,075,000	\$ 2,998,763			\$ 196,833	15				

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>005-1479000</u>	<u>Long-Term Care Facility</u>	\$ <u>81,586.94</u>	\$ <u>81,586.94</u>
2. <u>005-3910000</u>	<u>Land</u>	\$ <u>23.39</u>	\$ <u>23.39</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>81,610.33</u>	\$ <u>81,610.33</u>

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 X 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

N/A

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>Facility</u>	<u>418,945</u>	<u>2001</u>	<u>\$ 200,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	418,945		\$ 200,000	3

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	98	2001	1971	\$ 1,314,000	\$	35	\$ 37,543	\$ 37,543	\$ 281,572	4
5										5
6										6
7	Home Office Allocation									7
8										8
Improvement Type**										
9	Roof		2001	22,650		20	1,133	1,133	8,497	9
10	Flooring		2001	5,890		20	295	295	2,212	10
11	Landscaping		2001	8,984		20	449	449	3,368	11
12	A/C Heating Unit		2001	2,046		20	102	102	889	12
13	Fencing		2002	758		20	38	38	247	13
14	Roofing		2002	500		20	25	25	163	14
15	Ceiling Tiles		2003	9,516		20	476	476	2,618	15
16	Doors		2004	2,305		20	115	115	518	16
17	Nursing Station		2004	8,100		20	405	405	1,823	17
18	Furnace		2004	3,382		20	169	169	761	18
19	Water Heater		2004	2,281		20	114	114	513	19
20	Concrete slab work		2005	3,919		20	196	196	686	20
21	Roofing		2006	2,991		20	150	150	375	21
22	Walk-In Freezer		2007	14,817		20	741	741	1,111	22
23	Roof Repairs		2008	2,890		20	72	72	72	23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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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			33,692			(33,692)		43
44			4,871			(4,871)		44
45								45
46		949			61	61		46
47		14,178			340	340		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		\$ 1,420,156	\$ 38,563		\$ 42,424	\$ 3,861	\$ 305,425	70

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

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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	\$ 410,774	\$ 24,974	\$ 41,078	\$ 16,104		\$ 332,456	71
72	Current Year Purchases	6,197	275	310	35		310	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,166	5,166			74
75	TOTALS	\$ 416,971	\$ 25,249	\$ 46,554	\$ 21,305		\$ 332,766	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	\$ 46,577	\$	\$	\$	5	\$ 46,577	76
77	Facility Use	1999 Oldsmobile	2001	12,992				5	12,992	77
78	Facility Use	2001 Chevrolet	2003	10,002	576	1,002	426	5	10,002	78
79	Facility Use	1997 Jeep	2004	7,333	845	1,467	622	5	6,600	79
80	TOTALS			\$ 76,904	\$ 1,421	\$ 2,469	\$ 1,048		\$ 76,171	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)	\$ 2,114,031	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,233	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,447	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,214	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 714,362	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A

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: \$ 8,313 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			N/A		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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

Havana Health Care Center

0046086

Period Beginning

1/1/2008

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12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	1,797
Dishwasher		708
Copier		5,217
Home Office Allocation		591
		<u>8,313</u>

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>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>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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	2163 hrs	\$ 43,390	1	\$ 15		2,164	\$ 43,405	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	1 hrs	114	9	123	52	10	289	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				70,805		70,805	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 43,504	10	\$ 138	\$ 70,857	2,174	\$ 114,499	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 819,211	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>3</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 819,214	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	799,938	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)	\$ 799,938	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,619,152	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,009,568	1
2	Discounts and Allowances for all Levels	65,249	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,074,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	263,579	6
7	Oxygen	1,212	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 264,791	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	1,264	14
15	Telephone, Television and Radio	2,572	15
16	Rental of Facility Space		16
17	Sale of Drugs	112,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,435	20
21	Other Medical Services	15,468	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 159,710	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Jail Meals Revenue	149,352	28
28a	Miscellaneous Income	3,410	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 152,762	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,652,092	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	753,977	31
32	Health Care	1,162,036	32
33	General Administration	357,341	33
	B. Capital Expense		
34	Ownership	352,776	34
	C. Ancillary Expense		
35	Special Cost Centers	172,222	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,852,154	40
41	Income before Income Taxes (line 30 minus line 40)**	799,938	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 799,938	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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.

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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	1,985	\$ 45,934	\$ 23.14	1
2	Assistant Director of Nursing	2,080	42,276	20.33	2
3	Registered Nurses	4,023	89,161	21.19	3
4	Licensed Practical Nurses	16,169	267,120	15.97	4
5	CNAs & Orderlies	45,086	487,237	10.40	5
6	CNA Trainees				6
7	Licensed Therapist	2,098	43,502	20.71	7
8	Rehab/Therapy Aides				8
9	Activity Director	1,923	16,634	8.33	9
10	Activity Assistants	2,643	20,881	7.83	10
11	Social Service Workers	2,040	22,370	10.97	11
12	Dietician				12
13	Food Service Supervisor	2,561	32,742	12.78	13
14	Head Cook				14
15	Cook Helpers/Assistants	15,130	133,721	8.39	15
16	Dishwashers				16
17	Maintenance Workers	2,616	34,803	13.20	17
18	Housekeepers	9,660	90,864	9.17	18
19	Laundry	4,753	40,765	8.11	19
20	Administrator	2,197	67,892	30.07	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	2,080	25,363	12.19	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 C: Care Plan Coord.	2,080	39,244	18.87	32
33	Other(specify) <u>Marketing</u>	985	43,059	43.19	33
34	TOTAL (lines 1 - 33)	120,109	\$ 1,543,568 *	\$ 12.43	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	\$		35
36	Medical Director	Monthly 15,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	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)	\$ 16,700		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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	
<u>Angel Bollinger</u>	<u>Administrator</u>	<u>0</u>	\$ <u>21,633</u>	<u>Workers' Compensation Insurance</u>	\$ <u>22,559</u>	<u>IDPH License Fee</u>	\$ _____	
<u>Susan Showalter</u>	<u>Administrator</u>	<u>0</u>	<u>46,259</u>	<u>Unemployment Compensation Insurance</u>	<u>21,812</u>	<u>Advertising: Employee Recruitment</u>	<u>1,506</u>	
				<u>FICA Taxes</u>	<u>116,060</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>40,988</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>129</u> <u>1,290</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>375</u>	
				<u>Employee Relations</u>	<u>1,761</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>60</u>	
				<u>Employee Retirement</u>	<u>2,694</u>	<u>IHCA Dues</u>	<u>3,790</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>67,892</u>			<u>Home Office Allocation</u>	<u>1,315</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
<u>N/A</u>			\$ _____				Less: Public Relations Expense (_____)	
							Non-allowable advertising (_____)	
							Yellow page advertising (_____)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____				\$ <u>8,336</u>	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee		Type	Amount	Line #	Amount	Amount		
<u>Gallatin River Commun.</u>		<u>Computer Services</u>	\$ <u>390</u>		\$ _____	<u>Out-of-State Travel</u> \$ _____		
<u>E-Health Data Solution</u>		<u>Computer Services</u>	<u>2,700</u>					
<u>CenturyTel</u>		<u>Computer Services</u>	<u>511</u>					
<u>LTC Solutions</u>		<u>Computer Services</u>	<u>1,600</u>			<u>In-State Travel</u> _____		
<u>Robert McQuellon Consulting</u>		<u>Reversal of 2005 Fees</u>	<u>(2,185)</u>	<u>N/A</u>				
						<u>Seminar Expense</u> _____		
						<u>Home Office Allocation</u> <u>289</u>		
						<u>Entertainment Expense</u> (_____)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>3,016</u>	TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)						\$ <u>289</u>		

* Attach copy of IMRF notifications

**See instructions.

Havana Health Care Center

0046086

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		3,016

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	155
GoffWilson, P.A.	Legal	518
Ginoli & Company	Accountants	1,258
RSM McGladrey	Accountants	12
Miscellaneous Vendors	Computer Services	60
Emdeon Business Services	Computer Services	83
Advanced Answers on Demand	Computer Services	980
Access 2 Go	Computer Services	289
Ivans	Computer Services	150
Kemper Technology	Computer Services	531
VisionShare	Computer Services	57
Logmein	Computer Services	41
Comm Net Communiations	Computer Services	15
Charter Communications	Computer Services	13
Advanced System Designs	Computer Services	19
Consolidated Communications	Computer Services	11
Miscellaneous Vendors	Miscellaneous	72

Total (agree to Schedule V, line 19, column 8)		<u>7,280</u>
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Havana Health Care Center

0046086

Period Beginning

1/1/2008

Period End

12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angel Bollinger	Adminstrator	0	21,633
Susan Showalter	Adminstrator	0	46,259
	Total		<u>67,892</u>

Facility Name & ID Number Havana Health Care Center# 0046086

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 3,790 -IHCA
- (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? No
- (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 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,802
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 150,616
- (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. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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 currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees