

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205 Report Period Beginning: 6/2/08 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	45	Skilled (SNF)	45	9,585	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	9,585	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	4,749	1,603	415	6,767	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,749	1,603	415	6,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.60%

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)
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 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 6/2/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/2/08 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 45 and days of care provided 415

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL 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

LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	71,000	3,552		74,552		74,552	(5,320)	69,232		1
2	Food Purchase		40,389		40,389		40,389	(12,804)	27,585		2
3	Housekeeping	29,144	4,179		33,323		33,323	(2,907)	30,416		3
4	Laundry	12,925	1,064	6,715	20,704		20,704	(1,811)	18,893		4
5	Heat and Other Utilities			38,913	38,913		38,913	(3,280)	35,633		5
6	Maintenance	8,348	5,259	16,523	30,130		30,130	(1,901)	28,229		6
7	Other (specify):* Home Off. Ben. All.							296	296		7
8	TOTAL General Services	121,417	54,443	62,151	238,011		238,011	(27,727)	210,284		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	298,210	18,885	8,511	325,606		325,606	1,472	327,078		10
10a	Therapy			80,860	80,860		80,860		80,860		10a
11	Activities	8,225	537	390	9,152		9,152		9,152		11
12	Social Services	21,763	57		21,820		21,820		21,820		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							3,709	3,709		15
16	TOTAL Health Care and Programs	328,198	19,479	96,761	444,438		444,438	5,181	449,619		16
	C. General Administration										
17	Administrative	31,850		55,000	86,850		86,850	(45,637)	41,213		17
18	Directors Fees										18
19	Professional Services			3,130	3,130		3,130	1,743	4,873		19
20	Dues, Fees, Subscriptions & Promotions			1,912	1,912		1,912	439	2,351		20
21	Clerical & General Office Expenses	6,140	2,065	6,811	15,016		15,016	12,775	27,791		21
22	Employee Benefits & Payroll Taxes			65,976	65,976		65,976		65,976		22
23	Inservice Training & Education			1,057	1,057		1,057	92	1,149		23
24	Travel and Seminar							72	72		24
25	Other Admin. Staff Transportation			3,862	3,862		3,862	1,158	5,020		25
26	Insurance-Prop.Liab.Malpractice			6,002	6,002		6,002	87	6,089		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	37,990	2,065	143,750	183,805		183,805	(29,271)	154,534		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	487,605	75,987	302,662	866,254		866,254	(51,817)	814,437		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

LaHarpe Davier Health Care Center

#0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

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			6,541	6,541		6,541	(243)	6,298		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							3,951	3,951		32
33	Real Estate Taxes			4,900	4,900		4,900	172	5,072		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			4,111	4,111		4,111	163	4,274		35
36	Other (specify):*										36
37	TOTAL Ownership			15,552	15,552		15,552	4,043	19,595		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		7,410		7,410		7,410		7,410		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			14,447	14,447		14,447		14,447		42
43	Other (specify):* Non-allowable Cost		108	16,414	16,522		16,522	(16,522)			43
44	TOTAL Special Cost Centers		7,518	30,861	38,379		38,379	(16,522)	21,857		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	487,605	83,505	349,075	920,185		920,185	(64,296)	855,889		45

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

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

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				4
5	Telephone, TV & Radio in Resident Rooms	(330)	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	(1,291)	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(201)	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	(1,448)	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	(11,965)	43		24
25	Fund Raising, Advertising and Promotional	(1,809)	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	(32,094)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,141)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(15,155)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,155)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (64,296)		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

BHF USE ONLY

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

LaHarpe Davier Health Care Center

ID# 0049205

Report Period Beginning: 6/2/08

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (308)	43	1
2	X-Rays-Part A	(292)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(616)	10	3
4	Offset Miscellaneous Food Revenue	(9,290)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(21)	21	5
6	Resident Flowers	(132)	43	6
7	Disallowed Special Events	(37)	43	7
8	Independent Living Meal Cost	(3,534)	2	8
9	Independent Living Housekeeping Cost	(2,916)	3	9
10	Independent Living Utilities Cost	(3,405)	5	10
11	Independent Living Maintenance Cost	(2,636)	6	11
12	Independent Living Laundry Cost	(1,812)	4	12
13	Independent Living Dietary Cost	(6,523)	1	13
14	Independent Living Depreciation	(572)	30	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(32,094)		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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,203	\$ 1,203	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	20	20	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	9	9	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	125	125	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	735	735	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	296	296	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,088	2,088	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%	364	364	10
11	V	17 Administrative	55,000	Petersen Health Care, Inc.	100.00%	9,363	(45,637)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,057	1,057	12
13	V							13
14	Total		\$ 55,000			\$ 15,261	\$ * (39,739)	14

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

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning: 6/2/08

Ending: 12/31/2008

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	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	Petersen Health Care, Inc.	100.00%	\$ 326	\$ 326	15
16	V	21	Clerical and General Office	Petersen Health Care, Inc.	100.00%	11,750	11,750	16
17	V	23	Inservice Training and Education	Petersen Health Care, Inc.	100.00%	71	71	17
18	V	24	Travel and Seminar	Petersen Health Care, Inc.	100.00%	72	72	18
19	V	25	Other Admin. Staff Transportation	Petersen Health Care, Inc.	100.00%	925	925	19
20	V	26	Insurance-Prop./Liab/Malpractice	Petersen Health Care, Inc.	100.00%	56	56	20
21	V	27	Mgmt. Allocation of Benefits	Petersen Health Care, Inc.	100.00%	3,345	3,345	21
22	V	30	Depreciation	Petersen Health Care, Inc.	100.00%	1,280	1,280	22
23	V	32	Interest	Petersen Health Care, Inc.	100.00%	900	900	23
24	V	33	Real Estate Taxes	Petersen Health Care, Inc.	100.00%	172	172	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%	146	146	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		\$			\$ 19,043	\$ * 19,043	39

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

Facility Name & ID Number

LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending: 12/31/2008

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	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	686	686	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	113	113	27
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	1,046	1,046	28
29	V	23 Inservice Training & Education		Petersen Companies, LLC	100.00%	21	21	29
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	233	233	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	31	31	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	340	340	34
35	V	32 Interest		Petersen Companies, LLC	100.00%	3,054	3,054	35
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	17	17	38
39	Total		\$			\$ 5,541	\$ * 5,541	39

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

Facility Name & ID Number

LaHarpe Davier Health Care Center

#

0049205

Report Period Beginning:

6/2/08

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	1,819,310	0.48	0.80	Salary	9,363	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,363		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

0049205

Report Period Beginning:

6/2/08

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	6,767	\$ 1,203	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	6,767	20	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	6,767	9	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	6,767	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	6,767	125	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	6,767	735	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	6,767	296	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	6,767	2,088	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	6,767	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	6,767	364	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	6,767	9,363	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	6,767	1,057	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	6,767	326	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	6,767	11,750	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	6,767	71	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	6,767	72	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	6,767	925	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	6,767	56	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	6,767	3,345	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	6,767	1,280	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	6,767	900	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	6,767	172	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	6,767	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	6,767	146	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 34,304	25

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205 Report Period Beginning: 6/2/08

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 Companies, LLC
 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	227,342	13	\$	6,767	\$	1
2	2	Food	Resident Days	227,342	13		6,767		2
3	3	Housekeeping	Resident Days	227,342	13		6,767		3
4	4	Laundry	Resident Days	227,342	13		6,767		4
5	5	Utilities	Resident Days	227,342	13		6,767		5
6	6	Maintenance	Resident Days	227,342	13		6,767		6
7	7	Mgmt. Allocation of Benefits	Resident Days	227,342	13		6,767		7
8	10	Nursing and Medical Records	Resident Days	227,342	13		6,767		8
9	10A	Therapy	Resident Days	227,342	13		6,767		9
10	15	Mgmt. Allocation of Benefits	Resident Days	227,342	13		6,767		10
11	17	Administrative	Resident Days	227,342	13		6,767		11
12	19	Professional Services	Resident Days	227,342	13	23,031	6,767	686	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	227,342	13	3,794	6,767	113	13
14	21	Clerical and General Office	Resident Days	227,342	13	35,146	6,767	1,046	14
15	23	Inservice Training & Education	Resident Days	227,342	13	706	6,767	21	15
16	24	Travel and Seminar	Resident Days	227,342	13		6,767		16
17	25	Other Admin. Staff Transport.	Resident Days	227,342	13	7,835	6,767	233	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	227,342	13	1,053	6,767	31	18
19	27	Mgmt. Allocation of Benefits	Resident Days	227,342	13		6,767		19
20	30	Depreciation	Resident Days	227,342	13	11,428	6,767	340	20
21	32	Interest	Resident Days	227,342	13	102,603	6,767	3,054	21
22	33	Real Estate Taxes	Resident Days	227,342	13		6,767		22
23	34	Rent-Facility and Grounds	Resident Days	227,342	13		6,767		23
24	35	Rent-Equipment & Vehicles	Resident Days	227,342	13	585	6,767	17	24
25	TOTALS					\$ 186,181	\$	\$ 5,541	25

Facility Name & ID Number LaHarpe Davier Health Care Center # 0049205 Report Period Beginning: 6/2/08 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							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$			\$	3,951	9			
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$		14			
15	TOTALS (line 9+line14)						\$	\$			\$	3,951	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 LaHarpe Davier Health Care Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0049205

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>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u></u>	\$ <u></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.

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944 B. General Construction Type: Exterior Wood Frame Brick/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).

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident</u>	<u>31,944</u>	<u>2008</u>	<u>\$ 25,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	31,944		\$ 25,000	3

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	45		2008	1977	\$ 200,000	\$	25	\$ 4,000	\$ 4,000	\$ 4,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9					\$	\$		\$	\$	\$	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	Building Booked					5,417			(5,417)		28
29	Building Improvement Booked					502			(502)		29
30											30
31											31
32	2008-Home Office Allocation-Land Improvements				400			26	26		32
33	2008-Home Office Allocation-Building Improvements				5,971			143	143		33
34	Disallow Independent Living Depreciation							(572)	(572)		34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	206,371	\$	5,919	\$	3,597	\$	(2,322)	\$	4,000	70

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

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

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	\$ 25,000	\$	\$ 1,250	\$ 1,250	10 yrs.	\$ 1,250	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,451	1,451			74
75	TOTALS	\$ 25,000	\$	\$ 2,701	\$ 2,701		\$ 1,250	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 256,371	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,919	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 6,298	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 379	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,250	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.

Facility Name & ID Number LaHarpe Davier Health Care Center

0049205

Report Period Beginning: 6/2/08

Ending: 12/31/2008

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: \$ 4,274 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.	_____	<u>/2009</u>	\$ _____
13.	_____	<u>/2010</u>	\$ _____
14.	_____	<u>/2011</u>	\$ _____

* 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

0049205

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Home Office Allocation	\$	163
Medical Equipment		849
Copier		2,337
Dietary Equipment		925
		<u>4,274</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)	hrs	\$	2,819	\$ 42,283	\$	2,819	\$ 42,283	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		82	1,232		82	1,232	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,482	37,235		2,482	37,235	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 prescrpts				7,410		7,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Respiratory Therapy</u>				8	110		8	110	13
14	TOTAL			\$	5,391	\$ 80,860	\$ 7,410	5,391	\$ 88,270	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.

STATE OF ILLINOIS

Facility Name & ID Number **LaHarpe Davier Health Care Center**

0049205

Report Period Beginning: **6/2/08**

Ending: **12/31/2008**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 41,636	\$ 41,636	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	169,846	169,846	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,178	11,178	6
7	Other Prepaid Expenses	5,224	5,224	7
8	Accounts Receivable (owners or related parties)	(23,228)	(23,228)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 204,656	\$ 204,656	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,595	25,000	13
14	Buildings, at Historical Cost	250,000	205,971	14
15	Leasehold Improvements, at Historical Cost	13,870	400	15
16	Equipment, at Historical Cost	4,143	25,000	16
17	Accumulated Depreciation (book methods)	(7,556)	(5,250)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 265,052	\$ 251,121	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 469,708	\$ 455,777	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 271,015	\$ 271,015	26
27	Officer's Accounts Payable	254,323	254,323	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,883	42,883	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,179	2,179	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,900	16,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	13,021	13,021	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 600,321	\$ 600,321	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 600,321	\$ 600,321	46
47	TOTAL EQUITY (page 18, line 24)	\$ (130,613)	\$ (144,544)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 469,708	\$ 455,777	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Costs allocated to prior cost report period	(26,656)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (26,656)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(103,957)	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)	\$ (103,957)	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)	\$ (130,613)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LaHarpe Davier Health Care Center# 0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008**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	\$ 729,577	1
2	Discounts and Allowances for all Levels	(8,625)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 720,952	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,830	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,830	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	3,227	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,000	16
17	Sale of Drugs	12,996	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,087	20
21	Other Medical Services	433	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,743	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	637	28
28a	<u>Meals on Wheels Revenue</u>	6,063	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,700	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 816,228	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	238,011	31
32	Health Care	444,438	32
33	General Administration	183,805	33
B. Capital Expense			
34	Ownership	15,552	34
C. Ancillary Expense			
35	Special Cost Centers	23,932	35
36	Provider Participation Fee	14,447	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 920,185	40
41	Income before Income Taxes (line 30 minus line 40)**	(103,957)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (103,957)	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.

Facility Name & ID Number **LaHarpe Davier Health Care Center**

0049205

Report Period Beginning:

6/2/08

Ending:

12/31/2008

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	1,236	1,276	\$ 29,717	\$ 23.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,479	1,499	34,119	22.76	3
4	Licensed Practical Nurses	4,146	4,245	64,166	15.12	4
5	CNAs & Orderlies	14,968	15,293	149,017	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	235	235	2,202	9.37	9
10	Activity Assistants	522	576	6,023	10.46	10
11	Social Service Workers	1,606	1,606	21,763	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,227	1,227	17,745	14.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,513	6,575	53,255	8.10	15
16	Dishwashers					16
17	Maintenance Workers	800	810	8,348	10.31	17
18	Housekeepers	3,182	3,198	29,144	9.11	18
19	Laundry	1,544	1,566	12,925	8.25	19
20	Administrator	1,222	1,222	31,850	26.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	610	610	6,140	10.07	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>Care Plan Coord.</u>	1,213	1,213	21,191	17.47	33
34	TOTAL (lines 1 - 33)	40,503	41,151	\$ 487,605 *	\$ 11.85	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 7,000	9(3)	36
37	Medical Records Consultant	Monthly 51	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 350	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)	\$ 7,401		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	122 5,492	10(3)	51
52	Certified Nurse Assistants/Aides	101 2,338	10(3)	52
53	TOTAL (lines 50 - 52)	223 \$ 7,830		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	
Lisa Trego	Administator	0	\$ 31,850	Workers' Compensation Insurance	\$ 7,832	IDPH License Fee	\$	
				Unemployment Compensation Insurance	7,363	Advertising: Employee Recruitment	1,226	
				FICA Taxes	35,315	Health Care Worker Background Check		
				Employee Health Insurance	14,749	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	15 150	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	536	
				Employee Relations	717	Home Office Allocation	439	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 31,850					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 55,000				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Home Office Allocation	72
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 55,000				(agree to Sch. V,	
(Attach a copy of any management service agreement)							line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount					
E-Health Data Solutions	Computer Services		\$ 1,350					
LaHarpe Telephone Company	Computer Services		180					
LTC Solutions	Computer Services		1,600					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,130					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

LaHarpe Davier Health Care Center

0049205

Period Beginning 6/2/2008

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)		3,130

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	65
GoffWilson, P.A.	Legal	218
Ginoli & Company	Accountants	1,695
RSM McGladrey	Accountants	5
Miscellaneous Vendors	Computer Services	25
Emdeon Business Services	Computer Services	35
Advanced Answers on Demand	Computer Services	413
Access 2 Go	Computer Services	122
Ivans	Computer Services	63
Kemper Technology	Computer Services	223
VisionShare	Computer Services	24
Logmein	Computer Services	17
Comm Net Communiations	Computer Services	6
Charter Communications	Computer Services	5
Advanced System Designs	Computer Services	8
Consolidated Communications	Computer Services	5
Miscellaneous Vendors	Miscellaneous	31
Total (agree to Schedule V, line 19, column 8)		<u>6,090</u>

Facility Name & ID Number LaHarpe Davier Health Care Center# 0049205Report Period Beginning: 6/2/08Ending: 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? NO
If YES, give association name and amount. _____
- (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. \$ 4,611 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. \$ 14,447
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. \$ 9,290
- (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? 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 services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

LaHarpe-Davier Health Care Center

0049205

Period Beginning 6/2/2008

Period End 12/31/2008

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	649	8.75%
Nursing Home	6,767	91.25%
	<u>7,416</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	74,552	8.75%	6,523	Census	1
Food	40,389	8.75%	3,534	Census	2
Housekeeping	33,323	8.75%	2,916	Census	3
Laundry	20,704	8.75%	1,812	Census	4
Utilities	38,913	8.75%	3,405	Census	5
Maintenance	30,130	8.75%	2,636	Census	6
Depreciation (Building)	<u>6,541</u>	8.75%	<u>572</u>	S/L Depr	30
Total	<u>244,552</u>		<u>21,398</u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on straight-line depreciation over an estimated useful life of 25 years. Independent Living overhead and depreciation cost have been offset on P5A.