

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0053538</u></p> <p>Facility Name: <u>LaHarpe-Davier Health Care Center</u></p> <p>Address: <u>101 North B Street, P.O. Box #547</u> <u>LaHarpe</u> <u>61450</u> Number City Zip Code</p> <p>County: <u>Hancock</u></p> <p>Telephone Number: <u>(217) 659-3222</u> Fax # <u>(217) 659-3017</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>6/2/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																												

Facility Name & ID Number LaHarpe-Davier Health Care Center

0053538 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	16,425	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	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,182	4,181	888	10,251	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,182	4,181	888	10,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.41%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Independent Living

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 6/2/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/2/2008 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 834

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0053538 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	111,256	6,186		117,442		117,442	(9,569)	107,873		1
2	Food Purchase		82,339		82,339		82,339	(16,100)	66,239		2
3	Housekeeping	74,213	9,771		83,984		83,984	(8,583)	75,401		3
4	Laundry	86	11,712		11,798		11,798	(934)	10,864		4
5	Heat and Other Utilities			38,818	38,818		38,818	(3,859)	34,959		5
6	Maintenance	32,100	3,004	27,958	63,062		63,062	(2,628)	60,434		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	217,655	113,012	66,776	397,443		397,443	(41,673)	355,770		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	570,260	46,520	3,811	620,591		620,591	4,942	625,533		10
10a	Therapy		48	113,972	114,020		114,020		114,020		10a
11	Activities	12,649			12,649		12,649	(8,524)	4,125		11
12	Social Services	45,485			45,485		45,485		45,485		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	628,394	46,568	135,783	810,745		810,745	(3,582)	807,163		16
	C. General Administration										
17	Administrative			166,300	166,300		166,300	(100,000)	66,300		17
18	Directors Fees										18
19	Professional Services			2,358	2,358		2,358	13,114	15,472		19
20	Dues, Fees, Subscriptions & Promotions			1,364	1,364		1,364	2,534	3,898		20
21	Clerical & General Office Expenses	30,613	525	10,390	41,528		41,528	25,546	67,074		21
22	Employee Benefits & Payroll Taxes			87,204	87,204		87,204	11,045	98,249		22
23	Inservice Training & Education							62	62		23
24	Travel and Seminar							1	1		24
25	Other Admin. Staff Transportation			6,600	6,600		6,600	1,895	8,495		25
26	Insurance-Prop.Liab.Malpractice			14,622	14,622		14,622	475	15,097		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	30,613	525	288,838	319,976		319,976	(45,328)	274,648		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	876,662	160,105	491,397	1,528,164		1,528,164	(90,583)	1,437,581		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

#0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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			21,651	21,651		21,651	5,359	27,010			30
31	Amortization of Pre-Op. & Org.							3,835	3,835			31
32	Interest			230,774	230,774		230,774	20,217	250,991			32
33	Real Estate Taxes			29,734	29,734		29,734	188	29,922			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,278	6,278		6,278	547	6,825			35
36	Other (specify):*											36
37	TOTAL Ownership			288,437	288,437		288,437	30,146	318,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,177		20,177		20,177		20,177			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,106	80,106		80,106		80,106			42
43	Other (specify):* Miscellaneous			18,690	18,690		18,690	(18,690)				43
44	TOTAL Special Cost Centers		20,177	98,796	118,973		118,973	(18,690)	100,283			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	876,662	180,282	878,630	1,935,574		1,935,574	(79,127)	1,856,447			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	(2,073)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,077)	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	2,924	30		9
10	Interest and Other Investment Income	(1,806)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	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	(11,112)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	39	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	(61,895)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,329)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,798)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,798)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (79,127)		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

LaHarpe-Davier Health Care Center

ID# 0053538

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,682)	43	1
2	X-Rays-Part A	(1,392)	43	2
3	Offset Transportation Revenue	(8,524)	11	3
4	Pet Expense	(837)	43	4
5	Disallowed Special Events	(300)	43	5
6	Meals on Wheels Offset	(5,596)	2	6
7	Offset Miscellaneous Nursing Supplies Revenue	(20)	10	7
8	Independent Living Dietary Cost Offset	(12,059)	1	8
9	Independent Living Food Cost Offset	(8,454)	2	9
10	Independent Living Housekeeping Cost Offset	(8,623)	3	10
11	Independent Living Laundry Cost Offset	(1,211)	4	11
12	Independent Living Utilities Cost Offset	(3,986)	5	12
13	Independent Living Maintenance Cost Offset	(3,604)	6	13
14	Independent Living Depreciation Cost Offset	(3,607)	30	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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32				32
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(61,895)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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 Management, Inc.	100.00%	\$ 2,490	\$ 2,490	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	23	23	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	40	40	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	127	127	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	976	976	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	1,723	1,723	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	88,300	Petersen Health Care Management, Inc.	100.00%	66,300	(22,000)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	7,536	7,536	12
13	V							13
14	Total		\$ 88,300			\$ 79,215	\$ * (9,085)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 1,847	\$	1,847	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,546		25,546	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,729		10,729	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	62		62	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	1		1	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,895		1,895	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	475		475	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	6,042		6,042	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	55		55	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	1,589		1,589	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	188		188	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	547		547	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		\$			\$ 48,976	\$ *	48,976	39

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

Facility Name & ID Number LaHarpe-Davier Health Care Center# 0053538Report Period Beginning: 1/1/2018Ending: 12/31/2018

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 Health Business, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Business, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	277	277
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	3,239	3,239
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0	
24	V	17 Administrative	78,000	Petersen Health Business, LLC	100.00%	0	(78,000)
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	5,578	5,578
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	687	687
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	316	316
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0	
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0	
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	3,780	3,780
35	V	32 Interest		Petersen Health Business, LLC	100.00%	20,434	20,434
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0	
39	Total		\$ 78,000			\$ 34,311	\$ * (43,689)

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

Facility Name & ID Number

LaHarpe-Davier Health Care Center

0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

LaHarpe-Davier Health Care Center

0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number LaHarpe-Davier Health Care Center # 0053538 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaHarpe-Davier Health Care Center

0053538

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	1,411,762	75	\$ 342,871	\$ 393,211	10,251	\$ 2,490	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	10,251	23	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	10,251	40	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	10,251	127	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	10,251	976	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	10,251	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	10,251	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	10,251	1,723	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	10,251	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	10,251	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	10,251	66,300	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	10,251	7,536	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	10,251	1,847	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	10,251	25,546	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	10,251	10,729	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	10,251	62	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	10,251	1	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	10,251	1,895	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	10,251	475	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	10,251	6,042	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	10,251	55	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	10,251	1,589	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	10,251	188	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	10,251	547	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 128,191	25

Facility Name & ID Number LaHarpe-Davier Health Care Center

0053538

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Business, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309)691-8113
 Fax Number (309)691-8622

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	150,333	9	\$	\$	10,251	\$	1
2	2	Food	Resident Days	150,333	9			10,251		2
3	3	Housekeeping	Resident Days	150,333	9			10,251		3
4	4	Laundry	Resident Days	150,333	9	4,068		10,251	277	4
5	5	Utilities	Resident Days	150,333	9			10,251		5
6	6	Maintenance	Resident Days	150,333	9			10,251		6
7	7	Mgmt. Allocation of Benefits	Resident Days	150,333	9			10,251		7
8	10	Nursing and Medical Records	Resident Days	150,333	9	47,503		10,251	3,239	8
9	15	Mgmt. Allocation of Benefits	Resident Days	150,333	9			10,251		9
10	17	Administrative	Resident Days	150,333	9			10,251		10
11	19	Professional Services	Resident Days	150,333	9	81,804		10,251	5,578	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	150,333	9	10,073		10,251	687	12
13	21	Clerical and General Office	Resident Days	150,333	9			10,251		13
14	22	Employee Benefits & Payroll	Resident Days	150,333	9	4,639		10,251	316	14
15	23	Inservice Training & Education	Resident Days	150,333	9			10,251		15
16	24	Travel and Seminar	Resident Days	150,333	9			10,251		16
17	25	Other Admin. Staff Transport.	Resident Days	150,333	9			10,251		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	150,333	9			10,251		18
19	30	Depreciation	Resident Days	150,333	9			10,251		19
20	31	Amortization	Resident Days	150,333	9	55,441		10,251	3,780	20
21	32	Interest	Resident Days	150,333	9	299,670		10,251	20,434	21
22	33	Real Estate Taxes	Resident Days	150,333	9			10,251		22
23	34	Rent-Facility and Grounds	Resident Days	150,333	9			10,251		23
24	35	Rent-Equipment & Vehicles	Resident Days	150,333	9			10,251		24
25	TOTALS					\$ 503,198	\$		\$ 34,311	25

Facility Name & ID Number

LaHarpe-Davier Health Care Center

0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bank Leumi		X	Mortgage	Varies	1/1/2015	\$ 2,000,000	\$ 1,812,565	12/31/24	Varies	\$ 230,774	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,000,000	\$ 1,812,565			\$ 230,774	9						
B. Non-Facility Related*																		
10								Income Offset			(1,806)	10						
11								Home Office Allocation-PHB			20,434	11						
12								Home Office Allocation-PHCM			1,589	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 20,217	14						
15	TOTALS (line 9+line14)						\$ 2,000,000	\$ 1,812,565			\$ 250,991	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaHarpe-Davier Health Care Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0053538

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-21-405-010</u>	<u>Long-Term Care Facility</u>	\$ <u>29,734.36</u>	\$ <u>29,734.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>29,734.36</u></u>	\$ <u><u>29,734.36</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 NO

If YES, attach an explanation and 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944 B. General Construction Type: Exterior Brick Frame Brick/Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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? [X] YES [] NO

If so, please complete the following:

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 3,835 4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 31,944, 2008, \$ 25,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 31,944, (blank), \$ 25,000, 3.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	45	2008	1977	\$ 200,000	\$	25	\$ 8,000	\$ 8,000	\$ 84,000
5									
6									
7									
8									
Improvement Type**									
9	Water Heater		2011	3,534		7	504	504	3,780
10	Condenser		2012	3,680		7	526	526	3,419
11	Sprinkler System Replacement		2013	54,315		25	2,173	2,173	13,282
12	Vinyl Tile Replacement in Hallways, Office, and Common Area		2014	32,866		15	2,191	2,191	9,860
13	Elevator Repairs		2015	7,632		7	1,090	1,090	5,450
14	Roof Repair		2016	2,523		7	360	360	900
15	Repairs from Animal Damage		2017	5,443		7	778	778	1,167
16	Plumbing Repair		2017	3,011		7	430	430	645
17	Water Heater		2018	4,988		7	356	356	356
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				306			(306)	
31	Building Booked				7,930			(7,930)	
32	Building Improvement Booked				8,551			(8,551)	
33									
34	2018-Home Office Allocation-Building Improvements			4,822			116	116	
35	2018-Home Office Allocation-Land Improvements			484			31	31	
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

0053538

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 43,663	\$ 3,067	\$ 3,929	\$ 862	5-10 yrs.	\$ 26,264	71
72	Current Year Purchases	2,895	413	207	(206)	7 yrs.	207	72
73	Fully Depreciated Assets	24,769					24,769	73
74	Home Office Allocation			5,895	5,895			74
75	TOTALS	\$ 71,327	\$ 3,480	\$ 10,031	\$ 6,551		\$ 51,240	75

D. Vehicle Costs. (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	2010 Dodge Van	2018	\$ 4,239	\$ 1,384	\$ 424	\$ (960)	5 yrs.	\$ 424	76
77										77
78										78
79										79
80	TOTALS			\$ 4,239	\$ 1,384	\$ 424	\$ (960)		\$ 424	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)	\$ 423,864	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,651	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,010	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,359	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 174,523	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	Sprinkler System Replacement-2014	\$ 22,185	\$ 887	\$ 3,105	86
87	Elevator Repair-2015	3,118	445	1,558	87
88	Roof Repair-2016	732	52	156	88
89					89
90					90
91	TOTALS	\$ 26,035	\$ 1,384	\$ 4,819	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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 6,825 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

**LaHarpe-Davier Health Care Center
0053538**

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	3,763
Copier		2,515
Home Office Allocation		547
		<u>6,825</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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
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(2), 10A(3)	hrs	\$	3,443	\$ 51,650	\$ 48	3,443	\$ 51,698	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		372	5,576		372	5,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,783	56,746		3,783	56,746	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				20,177		20,177	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			\$	7,598	\$ 113,972	\$ 20,225	7,598	\$ 134,197	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,866,285	\$ 1,866,285	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>76,319</u>)	270,257	270,257	3
4	Supply Inventory (priced at <u>Cost</u>)	5,180	5,180	4
5	Short-Term Investments			5
6	Prepaid Insurance	9,371	9,371	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,151,093	\$ 2,151,093	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,595	25,000	13
14	Buildings, at Historical Cost	200,000	204,822	14
15	Leasehold Improvements, at Historical Cost	157,165	118,476	15
16	Equipment, at Historical Cost	75,566	75,566	16
17	Accumulated Depreciation (book methods)	(198,456)	(174,523)	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 (spe <u>Ind. Living Assets</u>)		26,035	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 263,870	\$ 275,376	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,414,963	\$ 2,426,469	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 319,098	\$ 319,098	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,965	43,965	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,744	5,744	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,358	60,358	32
33	Accrued Interest Payable	11,398	11,398	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	181,174	181,174	36
37	<u>Accrued Management Fees</u>	532,634	532,634	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,154,371	\$ 1,154,371	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,812,565	1,812,565	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)	\$ 1,812,565	\$ 1,812,565	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,966,936	\$ 2,966,936	46
47	TOTAL EQUITY(page 18, line 24)	\$ (551,973)	\$ (540,467)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,414,963	\$ 2,426,469	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (382,711)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (382,710)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(169,263)	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)	\$ (169,263)	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)	\$ (551,973)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number LaHarpe-Davier Health Care Center

0053538

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,524,262	1
2	Discounts and Allowances for all Levels	(65,460)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,458,802	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	27,150	5
6	Therapy	223,184	6
7	Oxygen	524	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 250,858	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	7,669	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	32,195	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,524	20
21	Other Medical Services	2,913	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46,301	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,806	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,806	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	8,524	28
28a	<u>Miscellaneous Revenue</u>	20	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,544	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,766,311	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	397,443	31
32	Health Care	810,745	32
33	General Administration	319,976	33
B. Capital Expense			
34	Ownership	288,437	34
C. Ancillary Expense			
35	Special Cost Centers	38,867	35
36	Provider Participation Fee	80,106	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,935,574	40
41	Income before Income Taxes (line 30 minus line 40)**	(169,263)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (169,263)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 641,465	44
45	Private Pay - Net Inpatient Revenue	598,097	45
46	Medicare - Net Inpatient Revenue	204,786	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	14,454	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,458,802	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number LaHarpe-Davier Health Care Center

0053538

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	1,592	1,724	\$ 53,875	\$ 31.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,012	1,026	26,826	26.15	3
4	Licensed Practical Nurses	7,721	7,809	176,692	22.63	4
5	CNAs & Orderlies	21,538	22,047	266,802	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	430	430	4,313	10.03	10
11	Social Service Workers	3,887	4,107	45,485	11.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,353	11,663	111,256	9.54	15
16	Dishwashers					16
17	Maintenance Workers	2,003	2,063	32,100	15.56	17
18	Housekeepers	4,829	5,073	74,213	14.63	18
19	Laundry	8	8	86	10.75	19
20	Administrator	2,080	2,080	66,300	31.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	30,613	14.72	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>Page 20A</u>	2,707	2,707	54,401	20.10	33
34	TOTAL (lines 1 - 33)	61,240	62,817	\$ 942,962 *	\$ 15.01	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 18,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,780	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	2 143	L10, C3	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)	2 \$ 20,923		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16 \$ 580	L10, C3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	16 \$ 580		53

LaHarpe-Davier Health Care Center
 0053538
 Period Beginning 1/1/2018
 Period End 12/31/2018

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,757	1,757	46,065	26.22
Transportation	950	950	8,336	8.77
TOTAL	2,707	2,707	54,401	

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	
Amy Tanner	Administrator	0	\$ 66,300	Workers' Compensation Insurance	\$ 11,894	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,010	Advertising: Employee Recruitment	604	
				FICA Taxes	65,239	Health Care Worker Background Check	150	
				Employee Health Insurance	1,661	(Indicate # of checks performed <u>5</u>)		
				Employee Meals		Patient Background Checks	202	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	408	
				Employee Relations	400	Home Office Allocation	2,534	
				Home Office Allocation	11,045			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,300	TOTAL (agree to Schedule V, line 22, col.8)		\$ 3,898		
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			\$ 166,300				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 166,300				Seminar Expense	
C. Professional Services				TOTAL			\$ 1	
Vendor/Payee	Type		Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Ability Network	Computer Services		\$ 1,843				TOTAL	
LaHarpe Telephone Company	Computer Services		515				\$ 1	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,358					

* Attach copy of IMRF notifications

**See instructions.

LaHarpe-Davier Health Care Center

0053538

Period Beginning

1/1/2018

Period End

12/31/2018

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,358

Home Office Allocation

Duane Morris	Legal	1030
Sedgwick CMS	Legal	91
SB2	Legal	254
Miscellaneous	Legal	76
Christoper P. Ryan	Legal	81
Saul Ewing Arnstein & Lehr	Legal	361
Healthcare Resources International	Legal	54
Winston & Strawn	Legal	868
Lexis Nexis	Legal	4
Pretzel & Stouffer	Legal	13
Baker Tilly Virchow Krause	Legal	205
Bank Leumi	Legal	1838
CliftonLarsonAllen	Accounting	527
Ginoli & Co.	Accounting	187
Duane Morris	Accounting	31
Getzler Henrich & Associates	Accounting	405
Kemper Consulting	Accounting	31
Baker Tilly Virchow Krause	Accounting	213
Ginoli & Co.	Accounting	1052
Miscellaneous	Computer Services	58
Change Healthcare	Computer Services	2
TR Professional	Computer Services	5
Matrix Care	Computer Services	592
Ability Network	Computer Services	937
Stratus Networks	Computer Services	229
Kemper Technology	Computer Services	263
AT&T	Computer Services	3
Ungerboeck Software	Computer Services	189
CIAN	Computer Services	82
Comcast	Computer Services	20
CCH	Computer Services	8
Charter Communications	Computer Services	14
Allscripts	Computer Services	266
ATS	Computer Services	124
Citrix Systems	Computer Services	43
Optimizer	Other Prof Fees	24
Sedgwick CLMS	Other Prof Fees	83
David Budde	Other Prof Fees	24
Sargent Consulting	Other Prof Fees	65
Alix Partners	Other Prof Fees	248
Getzler Henrich & Associates	Other Prof Fees	34
Getzler Henrich & Associates	Other Prof Fees	2,046
DFH Capital	Other Prof Fees	434

Total (agree to Schedule V, line 19, column 8)	<u>15,472</u>
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**LaHarpe-Davier Health Care Center
0053538**

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 14A

25. Administrative and Staff Transportation

Gas	\$	3,034
Auto Repairs		1,948
Mileage-Travel		1,618
Home Office Allocation		1,895
		<u>8,495</u>

Facility Name & ID Number LaHarpe-Davier Health Care Center# 0053538Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,199 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 80,106
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. \$ 2,073
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 8,524
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees

LaHarpe-Davier Health Care Center

0050831

Period Beginning 1/1/2018

Period End 12/31/2018

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	1,173	10.27%
Nursing Home	10,251	89.73%
	<u>11,424</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	117,442	10.27%	12,059	Census	1
Food	82,339	10.27%	8,454	Census	2
Housekeeping	83,984	10.27%	8,623	Census	3
Laundry	11,798	10.27%	1,211	Census	4
Utilities	38,818	10.27%	3,986	Census	5
Maintenance	35,104	10.27%	3,604	Census	6
Depreciation (Building)	21,651	10.27%	2,223	Census	30
Depreciation (Repairs)	<u>1,384</u>	100.00%	<u>1,384</u>	Census	30
Total	<u>392,520</u>		<u>41,545</u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.

Independent Living overhead and depreciation costs have been offset on P5A.

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-79,127	equal to	-79,127	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	250,991	equal to	250,991	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	29,922	equal to	29,922	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening	3,835	equal to	3,835	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	27,010	equal to	27,010	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,825	equal to	6,825	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	114,020	equal to	114,020	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	20,225	equal to	20,225	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	397,443	equal to	397,443	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	810,745	equal to	810,745	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	319,976	equal to	319,976	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	288,437	equal to	288,437	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	38,867	equal to	38,867	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+1	N/A	38to41+43	4
Income Stat. Prov. Partic.	80,106	equal to	80,106	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	570,260	equal to	570,260	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	12,649	equal to	12,649	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	45,485	equal to	45,485	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	111,256	equal to	111,256	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	32,100	equal to	32,100	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	74,213	equal to	74,213	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	86	equal to	86	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	66,300	equal to	66,300	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,613	equal to	30,613	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	942,962	equal to	876,662	66,300	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	18,000	< or = to	18,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,503	< or = to	3,811	-308	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	66,300	equal to	66,300	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	166,300	equal to	166,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	2,358	equal to	2,358	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	98,249	equal to	98,249	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,898	equal to	3,898	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1	equal to	1	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	80,106	equal to	80,106	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	834	equal to	888	-54	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. cost	-3,798	equal to	-3,798	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,812,565	equal to	1,812,565	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	60,358	equal to	60,358	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	25,000	equal to	25,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	323,298	equal to	323,298	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	75,566	equal to	75,566	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	174,523	equal to	174,523	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-551,973	equal to	-551,973	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-169,263	equal to	-169,263	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cr	0	equal to	0	0	O.K.	Pg22 F31-J31..	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,414,963	equal to	2,414,963	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Code	Description	Rate	Amount
100
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120

Code	Description	Rate	Amount
200
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220

Code	Description	Rate	Amount
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320

Code	Description	Rate	Amount
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Code	Description	Rate	Amount
500
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Code	Description	Rate	Amount
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Code	Description	Rate	Amount
700
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Code	Description	Rate	Amount
800
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819
820

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	111,256	6,186	0	117,442	0	117,442	-9,569	107,873
2. Food Purchase	0	82,339	0	82,339	0	82,339	-16,100	66,239
3. Housekeeping	74,213	9,771	0	83,984	0	83,984	-8,583	75,401
4. Laundry	86	11,712	0	11,798	0	11,798	-934	10,864
5. Heat and Other Utilities	0	0	38,818	38,818	0	38,818	-3,859	34,959
6. Maintenance	32,100	3,004	27,958	63,062	0	63,062	-2,628	60,434
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	217,655	113,012	66,776	397,443	0	397,443	-41,673	355,770
9. Medical Director	0	0	18,000	18,000	0	18,000	0	18,000
10. Nursing & Medical Records	570,260	46,520	3,811	620,591	0	620,591	4,942	625,533
10a. Therapy	0	48	113,972	114,020	0	114,020	0	114,020
11. Activities	12,649	0	0	12,649	0	12,649	-8,524	4,125
12. Social Services	45,485	0	0	45,485	0	45,485	0	45,485
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	628,394	46,568	135,783	810,745	0	810,745	-3,582	807,163
17. Administrative	0	0	166,300	166,300	0	166,300	-100,000	66,300
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,358	2,358	0	2,358	13,114	15,472
20. Fees, Subscriptions & Promotion	0	0	1,364	1,364	0	1,364	2,534	3,898
21. Clerical & General Office	30,613	525	10,390	41,528	0	41,528	25,546	67,074
22. Employee Benefits & Payroll	0	0	87,204	87,204	0	87,204	11,045	98,249
23. Inservice Training & Education	0	0	0	0	0	0	62	62
24. Travel and Seminar	0	0	0	0	0	0	1	1
25. Other Admin. Staff Trans	0	0	6,600	6,600	0	6,600	1,895	8,495
26. Insurance-Prop.Liab.Malpractice	0	0	14,622	14,622	0	14,622	475	15,097
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,613	525	288,838	319,976	0	319,976	-45,328	274,648
29. Total General Administrative	876,662	160,105	491,397	1,528,164	0	1,528,164	-90,583	#####
30. Depreciation	0	0	21,651	21,651	0	21,651	5,359	27,010
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	3,835	3,835
32. Interest	0	0	230,774	230,774	0	230,774	20,217	250,991
33. Real Estate	0	0	29,734	29,734	0	29,734	188	29,922
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	6,278	6,278	0	6,278	547	6,825
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	288,437	288,437	0	288,437	30,146	318,583
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	20,177	0	20,177	0	20,177	0	20,177
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	80,106	80,106	0	80,106	0	80,106
43. Other (specify):*	0	0	18,690	18,690	0	18,690	-18,690	0
44. Total Special Cost Ce	0	20,177	98,796	118,973	0	118,973	-18,690	100,283
45. Grand Total	876,662	180,282	878,630	1,935,574	0	1,935,574	-79,127	#####

		After
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,866,285	1,866,285
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	270,257	270,257
4. Supply Inventory	5,180	5,180
5. Short-Term Investments	0	0
6. Prepaid Insurance	9,371	9,371
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,151,093	2,151,093
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	29,595	25,000
14. Buildings, at Historical Cost	200,000	204,822
15. Leasehold Improvements, Historical Cost	157,165	118,476
16. Equipment, at Historical Cost	75,566	75,566
17. Accumulated Depreciation (book methods)	-198,456	-174,523
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	26,035
23. other (specify):	0	0
24. Total Long-Term Assets	263,870	275,376
25. Total Assets	2,414,963	2,426,469
CURRENT LIABILITIES		
26. Accounts Payable	319,098	319,098
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	43,965	43,965
31. Accrued Taxes Payable	5,744	5,744
32. Accrued Real Estate Taxes	60,358	60,358
33. Accrued Interest Payable	11,398	11,398
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	181,174	181,174
37. Other Current Liabilities (specify):	532,634	532,634
38. Total Current Liabilities	1,154,371	1,154,371
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,812,565	1,812,565
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,812,565	1,812,565
46.Total Liabilities	2,966,936	2,966,936
47.Total Equity	-551,973	-540,467
48.Total Liabilities and Equity	2,414,963	2,426,469

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,524,262
2. Discounts and Allowances for all Levels	-65,460
Subtotal - Inpatient Care	1,458,802
4. Day Care	0
5. Other Care for Outpatients	27,150
6. Therapy	223,184
7. Oxygen	524
Subtotal - Ancillary Revenue	250,858
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	7,669
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	32,195
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	3,524
21. Other Medical Services	2,913
22. Laundry	0
Subtotal - Other Operating Revenue	46,301
24. Contributions	0
25. Interest and Other Investments Income	1,806
Subtotal - Non-Operating Revenue	1,806
27. Other Revenue (specify):	8,524
28. Other Revenue (specify):	20
Subtotal - Other Revenue	8,544
30. Total Revenue	1,766,311
31. General Services	418,927
32. Health Care	827,975
33. General Administration	349,724
34. Ownership	149,656
35. Special Cost Centers	40,030
35. Provider Participation Fee	80,974
37. Other	0
40. Total Expenses	1,867,286
41. Income Before Income Taxes	-100,975
42. Income Taxes	0
43. Net Income or Loss for the Year	-100,975