

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Hlth Care Ctr</u></p> <p>Address: <u>101 North B St Bx547</u> <u>LaHarpe</u> <u>61450</u> <small>Number City Zip Code</small></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 <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </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 type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <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>1/1/2015</u> to <u>12/31/2015</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:15%; 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) _____ (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) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,925	5,444	1,409	14,778	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,925	5,444	1,409	14,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.97%

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)

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 6/2/2008

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 1,201

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

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	118,882	6,486	2,736	128,104		128,104	(11,077)	117,027		1
2	Food Purchase		100,661		100,661		100,661	(23,269)	77,392		2
3	Housekeeping	84,044	14,190		98,234		98,234	(10,436)	87,798		3
4	Laundry		23,337		23,337		23,337	(2,484)	20,853		4
5	Heat and Other Utilities			42,074	42,074		42,074	(4,331)	37,743		5
6	Maintenance	26,459	8,110	21,964	56,533		56,533	(5,002)	51,531		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	229,385	152,784	66,774	448,943		448,943	(56,599)	392,344		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	616,248	47,577	21,496	685,321		685,321	585	685,906		10
10a	Therapy			212,097	212,097		212,097		212,097		10a
11	Activities	19,764	176	212	20,152		20,152	(7,364)	12,788		11
12	Social Services	29,125			29,125		29,125		29,125		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	665,137	47,753	239,805	952,695		952,695	(6,779)	945,916		16
	C. General Administration										
17	Administrative			189,000	189,000		189,000	(125,270)	63,730		17
18	Directors Fees										18
19	Professional Services			9,162	9,162		9,162	26,178	35,340		19
20	Dues, Fees, Subscriptions & Promotions			6,544	6,544		6,544	309	6,853		20
21	Clerical & General Office Expenses	23,403	2,403	8,826	34,632		34,632	28,691	63,323		21
22	Employee Benefits & Payroll Taxes			118,333	118,333		118,333	19,104	137,437		22
23	Inservice Training & Education							197	197		23
24	Travel and Seminar							45	45		24
25	Other Admin. Staff Transportation			5,730	5,730		5,730	2,014	7,744		25
26	Insurance-Prop.Liab.Malpractice			14,120	14,120		14,120	309	14,429		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	23,403	2,403	351,715	377,521		377,521	(48,423)	329,098		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	917,925	202,940	658,294	1,779,159		1,779,159	(111,801)	1,667,358		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 Hlth Care Ctr

#0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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			23,286	23,286		23,286	3,033	26,319			30
31	Amortization of Pre-Op. & Org.							3,715	3,715			31
32	Interest			78,154	78,154		78,154	12,448	90,602			32
33	Real Estate Taxes			27,941	27,941		27,941	335	28,276			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,616	7,616		7,616	389	8,005			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			136,997	136,997		136,997	19,920	156,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,270		37,270		37,270		37,270			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,848	96,848		96,848		96,848			42
43	Other (specify):* Home Office Ben. Allocati		794	21,286	22,080		22,080	(22,080)				43
44	TOTAL Special Cost Centers		38,064	118,134	156,198		156,198	(22,080)	134,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	917,925	241,004	913,425	2,072,354		2,072,354	(113,961)	1,958,393			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 Hlth Care Ctr

0053538

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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	(5,313)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,120)	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	(711)	30		9
10	Interest and Other Investment Income	(244)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(312)	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	(14,304)	43		18
19	Entertainment				19
20	Contributions	(350)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,889)	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 Page 5A	(65,845)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,088)		\$	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)	(22,873)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,873)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (113,961)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

LaHarpe Davier Hlth Care Ctr

ID# 0053538

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (1,884)	43	1
2	X-Rays-Part A	(641)	43	2
3	Offset Transportation Revenue	(7,364)	11	3
4	Pet Expense	(1,088)	43	4
5	Resident Flowers	(782)	43	5
6	Disallowed Special Events	1,290	43	6
7	Meals on Wheels Offset	(7,245)	2	7
8	Offset Miscellaneous Nursing Supplies Revenue	507	10	8
9	Independent Living Dietary Cost Offset	(13,636)	1	9
10	Independent Living Food Cost Offset	(10,715)	2	10
11	Independent Living Housekeeping Cost Offset	(10,456)	3	11
12	Independent Living Laundry Cost Offset	(2,484)	4	12
13	Independent Living Utilities Cost Offset	(4,478)	5	13
14	Independent Living Maintenance Cost Offset	(6,017)	6	14
15	Independent Living Depreciation Cost Offset	(852)	30	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		(65,845)	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 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%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	129	129	12	
13	V							13	
14	Total		\$			\$ 129	\$ *	129	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 35	\$	35	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	500		500	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			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		\$			\$ 535	\$ *	535	39

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

Facility Name & ID Number

LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$	15	
16	V	2 Food		Petersen Health Business, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Business, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	19,978	19,978	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	129	129	26	
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	(83)	(83)	28	
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	3,349	3,349	34	
35	V	32 Interest		Petersen Health Business, LLC	100.00%	12,044	12,044	35	
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38	
39	Total		\$			\$ 35,417	\$ *	35,417	39

* 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	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,559	\$ 2,559
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	20	20
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	147	147
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,015	1,015
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	78	78
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	189,000	Petersen Health Care Management, Inc.	100.00%	63,730	(125,270)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	4,527	4,527
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	81	81
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	28,691	28,691
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	19,187	19,187
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	197	197
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	45	45
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,014	2,014
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	309	309
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	4,596	4,596
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	148	148
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	335	335
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	389	389
39	Total		\$ 189,000			\$ 128,072	\$ * (60,928)

* 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	1 Dietary	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	1,544	1,544	25	
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	64	64	26	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32	
33	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	0		33	
34	V	31 Amortization		Midwest Health Operations, LLC	100.00%	366	366	34	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 1,974	\$ *	1,974	39

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

Facility Name & ID Number

LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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 J	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 Syste	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	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr # 0053538 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	13,205	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	13,205	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	13,205	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	13,205	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	13,205	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,205	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	13,205	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	13,205	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	13,205	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,205	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	13,205	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	13,205	129	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	13,205	35	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	13,205	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	13,205	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	13,205	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	13,205	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	13,205	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	13,205	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,205	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	13,205	500	21
22	32	Interest	Resident Days	1,553,881	75	0	0	13,205	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	13,205	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	13,205	0	24
25	TOTALS					\$ 78,110	\$		\$ 664	25

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 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

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	135,444	9		10,909		1
2	2	Food	Resident Days	135,444	9		10,909		2
3	3	Housekeeping	Resident Days	135,444	9		10,909		3
4	4	Laundry	Resident Days	135,444	9		10,909		4
5	5	Utilities	Resident Days	135,444	9		10,909		5
6	6	Maintenance	Resident Days	135,444	9		10,909		6
7	7	Mgmt. Allocation of Benefits	Resident Days	135,444	9		10,909		7
8	10	Nursing and Medical Records	Resident Days	135,444	9		10,909		8
9	15	Mgmt. Allocation of Benefits	Resident Days	135,444	9		10,909		9
10	17	Administrative	Resident Days	135,444	9		10,909		10
11	19	Professional Services	Resident Days	135,444	9	248,045	10,909	19,978	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	135,444	9	1,598	10,909	129	12
13	21	Clerical and General Office	Resident Days	135,444	9		10,909		13
14	22	Employee Benefits & Payroll	Resident Days	135,444	9	(1,030)	10,909	(83)	14
15	23	Inservice Training & Education	Resident Days	135,444	9		10,909		15
16	24	Travel and Seminar	Resident Days	135,444	9		10,909		16
17	25	Other Admin. Staff Transport.	Resident Days	135,444	9		10,909		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	135,444	9		10,909		18
19	30	Depreciation	Resident Days	135,444	9		10,909		19
20	31	Amortization	Resident Days	135,444	9	41,581	10,909	3,349	20
21	32	Interest	Resident Days	135,444	9	149,539	10,909	12,044	21
22	33	Real Estate Taxes	Resident Days	135,444	9		10,909		22
23	34	Rent-Facility and Grounds	Resident Days	135,444	9		10,909		23
24	35	Rent-Equipment & Vehicles	Resident Days	135,444	9		10,909		24
25	TOTALS					\$ 439,733	\$	\$ 35,417	25

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 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

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	1,553,881	75	\$ 301,135	\$ 292,840	13,205	\$ 2,559	1
2	2	Food	Resident Days	1,553,881	75	480		13,205	4	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	13,205	20	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		13,205	147	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	13,205	1,015	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,205		6
7	9	Medical Director	Resident Days	1,553,881	75			13,205		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		13,205	78	8
9	10A	Therapy	Resident Days	1,553,881	75			13,205		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,205		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	13,205	63,730	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		13,205	4,527	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		13,205	81	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	13,205	28,691	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		13,205	19,187	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		13,205	197	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		13,205	45	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		13,205	2,014	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		13,205	309	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,205		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		13,205	4,596	21
22	32	Interest	Resident Days	1,553,881	75	17,439		13,205	148	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		13,205	335	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		13,205	389	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 128,072	25

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 Midwest Health Operations, 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	160585	10	\$	\$ 3,869	\$	1
2	2	Food	Resident Days	160585	10		3,869		2
3	3	Housekeeping	Resident Days	160585	10		3,869		3
4	4	Laundry	Resident Days	160585	10		3,869		4
5	5	Utilities	Resident Days	160585	10		3,869		5
6	6	Maintenance	Resident Days	160585	10		3,869		6
7	7	Mgmt. Allocation of Benefits	Resident Days	160585	10		3,869		7
8	10	Nursing and Medical Records	Resident Days	160585	10		3,869		8
9	15	Mgmt. Allocation of Benefits	Resident Days	160585	10		3,869		9
10	17	Administrative	Resident Days	160585	10		3,869		10
11	19	Professional Services	Resident Days	160585	10	64,091	3,869	1,544	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	160585	10	2,658	3,869	64	12
13	21	Clerical and General Office	Resident Days	160585	10		3,869		13
14	22	Employee Benefits & Payroll	Resident Days	160585	10		3,869		14
15	23	Inservice Training & Education	Resident Days	160585	10		3,869		15
16	24	Travel and Seminar	Resident Days	160585	10		3,869		16
17	25	Other Admin. Staff Transport.	Resident Days	160585	10		3,869		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	160585	10		3,869		18
19	27	Mgmt. Allocation of Benefits	Resident Days	160585	10		3,869		19
20	30	Depreciation	Resident Days	160585	10	15,190	3,869	366	20
21	32	Interest	Resident Days	160585	10		3,869		21
22	33	Real Estate Taxes	Resident Days	160585	10		3,869		22
23	34	Rent-Facility and Grounds	Resident Days	160585	10		3,869		23
24	35	Rent-Equipment & Vehicles	Resident Days	160585	10		3,869		24
25	TOTALS					\$ 81,939	\$	\$ 1,974	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank Leumi		X	Mortgage	Varies	1/1/2015	\$ 2,000,000	\$ 1,909,494	12/31/24	Varies	\$ 74,768					
2																
3							Interest Income Offset									
4																
5																
Working Capital																
6	Citizens First National Bank		X	Line of Credit		11/1/11	300,000	Retired			3,386					
7																
8																
9	TOTAL Facility Related						\$ 2,300,000	\$ 1,909,494			\$ 78,154					
B. Non-Facility Related*																
10								Home Office Allocation-PHC		500	10					
11								Home Office Allocation-PHB		12,044	11					
12								Home Office Allocation-PHCM		148	12					
13								Interest Income Offset		(244)	13					
14	TOTAL Non-Facility Related						\$	\$		\$ 12,448	14					
15	TOTALS (line 9+line14)						\$ 2,300,000	\$ 1,909,494		\$ 90,602	15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	29,004		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	28,049		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	(955)		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,896		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			Home Office Allocation 335		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	28,276		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>28,241</u>	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>28,065</u>	9																
	2012	<u>28,022</u>	10																
	2013	<u>28,162</u>	11																
	2014	<u>28,049</u>	12																
Accrual based on prior year tax bill.																			

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaHarpe Davier Hlth Care Ctr COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0053538

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 2014 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 2014.

(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>28,048.92</u>	\$ <u>28,048.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>28,048.92</u></u>	\$ <u><u>28,048.92</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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,944 B. General Construction Type: Exterior Brick Frame 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: 95,556 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 3,715 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</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

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	\$ 60,000	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Water Heater		2011	3,534		7	504	504	2,268	9
10	Condenser		2012	3,680		7	526	526	1,841	10
11	Sprinkler System Replacement		2013	76,500		25	3,060	3,060	7,650	11
12	Vinyl Tile Replacement in Hallways, Office, and Common Area		2014	32,866		15	2,191	2,191	3,287	12
13	Elevator Repairs		2015	10,750		7	768	768	768	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	Land Improvements Booked				306			(306)		29
30	Building Booked				7,930			(7,930)		30
31	Building Improvement Booked				7,476			(7,476)		31
32										32
33	2015-Home Office Allocation-Building Improvements			5,778			139	139		33
34	2015-Home Office Allocation-Land Improvements			539			34	34		34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		\$ 333,647	\$ 15,712		\$ 15,222	\$ (490)	\$ 75,814	70

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

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 65,050	\$ 7,171	\$ 6,505	\$ (666)	5-10 yrs.	\$ 39,077	71
72	Current Year Purchases	3,382	403	169	(234)	10 yrs.	169	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,423	4,423			74
75	TOTALS	\$ 68,432	\$ 7,574	\$ 11,097	\$ 3,523		\$ 39,246	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				\$	\$	\$	\$		\$	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)	\$ 427,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,319	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,033	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 115,060	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,005 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	<u>N/A</u>				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 Hlth Care Ctr
0053538
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 5,366
Dishwasher	119
Copier	2,131
Home Office Allocation	389
	<u>8,005</u>

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr # 0053538 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,057	\$ 75,857	\$	5,057	\$ 75,857	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,979	44,684		2,979	44,684	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,104	91,556		6,104	91,556	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				37,270		37,270	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			\$	14,140	\$ 212,097	\$ 37,270	14,140	\$ 249,367	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr# 0053538Report Period Beginning: 1/1/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(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	\$ 1,743,878	\$ 1,743,878	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>95,887</u>)	330,762	330,762	3
4	Supply Inventory (priced at <u>Cost</u>)	5,180	5,180	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,811	14,811	6
7	Other Prepaid Expenses	21,583	21,583	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	2,450	2,450	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,118,664	\$ 2,118,664	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	205,778	14
15	Leasehold Improvements, at Historical Cost	141,200	127,869	15
16	Equipment, at Historical Cost	68,432	68,432	16
17	Accumulated Depreciation (book methods)	(134,808)	(115,060)	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)	\$ 304,419	\$ 312,019	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,423,083	\$ 2,430,683	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 343,189	\$ 343,189	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,726	45,726	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,091	54,091	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,896	28,896	32
33	Accrued Interest Payable	8,221	8,221	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	108,685	108,685	36
37	<u>Accrued Management Fees</u>	412,978	412,978	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,001,786	\$ 1,001,786	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,909,494	1,909,494	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	86,498	86,498	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,995,992	\$ 1,995,992	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,997,778	\$ 2,997,778	46
47	TOTAL EQUITY(page 18, line 24)	\$ (574,695)	\$ (567,095)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,423,083	\$ 2,430,683	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,263,346	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	3,136	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,266,482	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	185,190	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)	\$ 185,190	17
B. Transfers (Itemize):			
18	Transfer of Net Assets	(2,026,367)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,026,367)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (574,695)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,992,812	1
2	Discounts and Allowances for all Levels	(181,072)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,811,740	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	28,200	5
6	Therapy	326,749	6
7	Oxygen	800	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 355,749	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	12,558	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	64,588	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,860	20
21	Other Medical Services	2,948	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 82,954	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	244	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 244	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	7,364	28
28a	<u>Miscellaneous Revenue</u>	(507)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,857	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,257,544	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	448,943	31
32	Health Care	952,695	32
33	General Administration	377,521	33
B. Capital Expense			
34	Ownership	136,997	34
C. Ancillary Expense			
35	Special Cost Centers	59,350	35
36	Provider Participation Fee	96,848	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,072,354	40
41	Income before Income Taxes (line 30 minus line 40)**	185,190	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 185,190	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,033,107	44
45	Private Pay - Net Inpatient Revenue	495,405	45
46	Medicare - Net Inpatient Revenue	241,914	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	43,627	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(2,313)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,811,740	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 Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	2,080	2,080	\$ 58,878	\$ 28.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,516	3,516	84,084	23.91	3
4	Licensed Practical Nurses	7,668	8,107	159,814	19.71	4
5	CNAs & Orderlies	23,944	24,860	254,497	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	873	890	7,767	8.73	10
11	Social Service Workers	1,647	1,647	29,125	17.68	11
12	Dietician					12
13	Food Service Supervisor	2,284	2,284	29,894	13.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,602	9,975	88,988	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,841	1,898	26,459	13.94	17
18	Housekeepers	8,460	8,633	84,044	9.74	18
19	Laundry					19
20	Administrator	1,996	2,036	63,730	31.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,928	2,024	23,403	11.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,010	2,050	57,151	27.88	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	1,314	1,379	13,821	10.02	33
34	TOTAL (lines 1 - 33)	69,163	71,379	\$ 981,655 *	\$ 13.75	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	50	\$ 2,736	L1, C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,798	L10, C3	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)	50	\$ 11,534		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

LaHarpe Davier Hlth Care Ctr
 0053538
 Period Beginning 1/1/2015
 Period End 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Restorative Salaries	208	208	1,824	8.77
Transportation	1,106	1,171	11,997	10.25
TOTAL	<u>1,314</u>	<u>1,379</u>	<u>13,821</u>	

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	
Athena Brooks	Administrator	0	\$ 46,173	Workers' Compensation Insurance	\$ 22,868	IDPH License Fee	\$ 3,980	
Jennifer Diggs	Administrator	0	17,557	Unemployment Compensation Insurance	35,172	Advertising: Employee Recruitment	621	
				FICA Taxes	64,871	Health Care Worker Background Check		
				Employee Health Insurance	(5,647)	(Indicate # of checks performed <u>123</u>)	1,043	
				Employee Meals		Miscellaneous Licenses & Permits	900	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		
				Employee Relations	1,069	Home Office Allocation	309	
				Home Office Allocation	19,104			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 63,730					
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			\$ 189,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 189,000				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	45
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V,	
E-Health Data Solutions	Computer Services	\$ 4,421					line 24, col. 8)	
LaHarpe Telephone Company	Computer Services	473					TOTAL	
Honkamp Krueger & Co.	Accounting Fees	768					\$ 45	
Consolidated Land Surveying	ALTA Survey Fees	3,500						
TOTAL (agree to Schedule V, line 19, column 3)				\$				
(For legal fee disclosure, see page 39 of instructions)			\$ 9,162					

* Attach copy of IMRF notifications

**See instructions.

LaHarpe Davier Hlth Care Ctr
0053538

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,162
Home Office Allocation		
Denton's US LLP	Legal	64
Applegate and Thorne	Legal	3288
Miller Hall and Triggs	Legal	10
Healthcare Resources International	Legal	53
Lexis Nexis	Legal	4
GoffWilson	Legal	440
Private Bank	Legal	
Illinois Secretary of State	Legal	20
Lashley & Baer	Legal	238
CliftonLarson Allen	Accountants	687
Ginoli & Co.	Accountants	1,101
Miscellaneous	Computer Services	31
CCH	Computer Services	8
PTC Select	Computer Services	10
Advanced Answers on Demand	Computer Services	1409
Stratus Networks	Computer Services	256
Kemper Technology	Computer Services	377
AT&T	Computer Services	3
Ability Network	Computer Services	363
CIAN	Computer Services	255
Comcast	Computer Services	10
Emdeon	Computer Services	21
Charter Communications	Computer Services	17
Allscripts	Computer Services	13
Allpayer Exchange	Computer Services	8

E-Health Technologies	Computer Services	6
Macquarie Technology Services	Computer Services	9
Optimizer	Other Prof Fees	25
D.J. Howard Appraisers	Other Prof Fees	22
Key Corporate Services	Other Prof Fees	75
Consolidated Land Surveying	Other Prof Fees	47
Alan Litwiller	Other Prof Fees	10
Marotta Gund Budd Derza	Other Prof Fees	17290
Registered Agent Services	Other Prof Fees	8

Total (agree to Schedule V, line 19, column 8)		<u>35,340</u>
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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number LaHarpe Davier Hlth Care Ctr

0053538

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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. N/A
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,752 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. \$ 96,848
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. \$ 5,313
- (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. \$ 7,364
- 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? Yes
- 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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

LaHarpe-Davier Health Care Center

0050831

Period Beginning 1/1/2015

Period End 12/31/2015

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	1,573	10.64%
Nursing Home	13,205	89.36%
	<u>14,778</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	128,104	10.64%	13,636	Census	1
Food	100,661	10.64%	10,715	Census	2
Housekeeping	98,234	10.64%	10,456	Census	3
Laundry	23,337	10.64%	2,484	Census	4
Utilities	42,074	10.64%	4,478	Census	5
Maintenance	56,533	10.64%	6,017	Census	6
Depreciation (Building)	<u>8,000</u>	10.64%	<u>852</u>	Beds	30
Total	<u><u>456,943</u></u>		<u><u>48,638</u></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.