

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: <u>0046896</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER										
Facility Name: <u>White Hall Nsg & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said content: 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										
Address: <u>620 W Bridgeport St</u> <u>White Hall</u> <u>62092</u> Number City Zip Code		Intentional misrepresentation or falsification of any informatior in this cost report may be punishable by fine and/or imprisonment										
County: <u>Greene</u>												
Telephone Number: <u>(217) 374-2144</u> Fax # <u>(217) 374-6714</u>												
HFS ID Number: _____												
Date of Initial License for Current Owners: <u>January 1, 2005</u>												
Type of Ownership:												
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____	☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____	☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____										
In the event there are further questions about this report, please contact: Name: <u>Gary F. Eye</u> Telephone Number: <u>(716) 972-2392</u> Email Address: _____		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Gary F. Eye</u></td> </tr> <tr> <td rowspan="5"> Paid Preparer </td> <td>(Title) <u>Senior VP of Finance of Tara Cares</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Gary F. Eye</u>	Paid Preparer	(Title) <u>Senior VP of Finance of Tara Cares</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>
Officer or Administrator of Provider	(Signed) _____ (Date) _____											
	(Type or Print Name) <u>Gary F. Eye</u>											
Paid Preparer	(Title) <u>Senior VP of Finance of Tara Cares</u>											
	(Signed) _____ (Date) _____											
	(Print Name and Title) _____											
	(Firm Name & Address) _____											
	(Telephone) <u>()</u> Fax # <u>()</u>											
		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										

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>119</u>	Skilled (SNF)	<u>119</u>	<u>43,554</u>	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	<u>119</u>	TOTALS	<u>119</u>	<u>43,554</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,079</u>	<u>8,230</u>	<u>5,388</u>	<u>39,697</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,079</u>	<u>8,230</u>	<u>5,388</u>	<u>39,697</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.14%D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
outpatient therapyF. Does the facility maintain a daily midnight census? YesG. 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 01/01/2005J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date January 1, 2005 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 119 and days of care provided 4,430Medicare Intermediary Wisconsin Physicians Insurance Corp (WSP)

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 1/1 to 12/31/16 Fiscal Year: 1/1 to 12/31/16

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	
1	A. General Services											
1	Dietary	237,430	22,717	15,025	275,172		275,172	20	275,192			1
2	Food Purchase		248,881		248,881		248,881	(3,233)	245,648			2
3	Housekeeping	161,819	20,639	40	182,498		182,498	(233)	182,265			3
4	Laundry	62,335	11,698		74,033		74,033	(439)	73,594			4
5	Heat and Other Utilities			108,305	108,305		108,305		108,305			5
6	Maintenance	54,374	42,066	34,312	130,752		130,752	(12,226)	118,526			6
7	Other (specify):* see trial balance			15,705	15,705		15,705		15,705			7
8	TOTAL General Services	515,958	346,001	173,387	1,035,346		1,035,346	(16,111)	1,019,235			8
9	B. Health Care and Programs											
9	Medical Director			16,068	16,068		16,068		16,068			9
10	Nursing and Medical Records	2,109,623	205,516	71,377	2,386,516		2,386,516	(10,872)	2,375,644			10
10a	Therapy		6,413	978,519	984,932		984,932	(169,821)	815,111			10a
11	Activities	70,774	5,338	2,886	78,998		78,998	300	79,298			11
12	Social Services	86,650	1,463	2,295	90,408		90,408	288	90,696			12
13	CNA Training			916	916		916		916			13
14	Program Transportation			37,312	37,312		37,312	(3,458)	33,854			14
15	Other (specify):* see trial balance			14,396	14,396		14,396	(6,836)	7,560			15
16	TOTAL Health Care and Programs	2,267,047	218,730	1,123,769	3,609,546		3,609,546	(190,399)	3,419,147			16
17	C. General Administration											
17	Administrative	281,617		387,132	668,749		668,749	(133,235)	535,514			17
18	Directors Fees											18
19	Professional Services			45,469	45,469		45,469	(2,438)	43,031			19
20	Dues, Fees, Subscriptions & Promotions			53,286	53,286		53,286	(33,880)	19,406			20
21	Clerical & General Office Expenses		82,416	69,508	151,924		151,924	(23,144)	128,780			21
22	Employee Benefits & Payroll Taxes			494,326	494,326		494,326	1,572	495,898			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,564	25,564		25,564		25,564			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,762	96,762		96,762	(2,600)	94,162			26
27	Other (specify):* see trial balance			262,872	262,872		262,872	(249,903)	12,969			27
28	TOTAL General Administration	281,617	82,416	1,434,919	1,798,952		1,798,952	(443,628)	1,355,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,064,622	647,147	2,732,075	6,443,844		6,443,844	(650,138)	5,793,706			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.

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			217,889	217,889		217,889	60,301	278,190			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							339,557	339,557			32
33	Real Estate Taxes			149,032	149,032		149,032		149,032			33
34	Rent-Facility & Grounds			820,800	820,800		820,800	(820,800)				34
35	Rent-Equipment & Vehicles			41,617	41,617		41,617	309	41,926			35
36	Other (specify):* Off Site Storage			752	752		752		752			36
37	TOTAL Ownership			1,230,090	1,230,090		1,230,090	(420,633)	809,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,009	280,009		280,009		280,009			42
43	Other (specify):* see trial balance			263,336	263,336		263,336	(89,477)	173,859			43
44	TOTAL Special Cost Centers			543,345	543,345		543,345	(89,477)	453,868			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,064,622	647,147	4,505,510	8,217,279		8,217,279	(1,160,248)	7,057,031			45

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

	1	2	3	
	Amount	Refer-ence	BHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,945)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds	(89)	21		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(236)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(1,430)	21		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(257,455)	27		24
25 Fund Raising, Advertising and Promotional	(30,676)	20		25
Income Taxes and Illinois Persona				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(261,468)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (554,299)		\$	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
Amortization of Organization & Pre-Operating Expense			
33 Adjustments for Related Organization			33
34 Costs (Schedule VII)	(605,949)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (605,949)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,160,248)		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				45
46 Other-Attach Schedule				46
47 TOTAL (C): (sum of lines 38-46)			\$	47

White Hall Nsg & Rehab Ctr

ID# 0046896

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues&Subscriptions	\$ (3,028)	20	1
2	Remove Non-allowable Admiss Dues & Subscriptions	(135)	20	2
3	Remove Non-allowable Admissions Other Supplies	(19,294)	21	3
4	Remove Non-allowable Dental - Physician Fees	(4,844)	43	4
5	Remove Non-allowable Insurance Cost	(2,600)	26	5
6	Remove Non-allowable Admin Other Supplies	(620)	21	6
7	Remove Non-allowable NRS Admin - Rental/Lease	(1)	35	7
8	Remove Non-allowable Finance Charges	(414)	21	8
9	Remove Non-allow Admin - Other Purchased Svcs	(1,289)	27	9
10	Remove Non-allowable Admiss-Rental/Lease	(100)	35	10
11	Remove Non-allowable NRS Admin- Res Transport	(3,458)	14	11
12	Remove Non-allowable HR-EE background checks	(41)	20	12
13	Remove Non-allowable BO Tax Preperation Fees	(2,438)	19	13
14	Remove Non-allow Outpatient Svcs-consol billing	(465)	43	14
15	Additional Allowable Dietary	20	1	15
16	Additional Allowable Food	(52)	2	16
17	Additional Allowable Maintenance	(1,599)	6	17
18	Additional Allowable Laundry	(439)	4	18
19	Additional Allowable Nursing and Med. Records	1,114	10	19
20	Additional Allowable Activities	300	11	20
21	Additional Allowable Social Services	288	12	21
22	Additional Allowable Therapy	35	10a	22
23	Additional Allow Clerical & General Office Exp	109	21	23
24	Additional Allowable EE Benefits	1,890	22	24
25	Additional Allowable Rent - Equipment	410	35	25
26	Additional Allowable ADR submission	10	27	26
27	Remove Non-allowable IV Rx Drugs Cost	(2,687)	43	27
28	Remove Non-allowable Prior Year Costs	(6,887)	43	28
29	Offset Interco Sold Services Revenue	(905)	6	29
30	Offset Interco Sold Services Revenue	(250)	17	30
31	Offset Interco Sold Services Revenue	(138)	17	31
32	Offset Interco Sold Services Revenue	(897)	17	32
33	Offset Interco Sold Services Revenue	(655)	10	33
34	Offset Interco Sold Services Revenue	(233)	3	34
35	Offset Interco Sold Services Revenue	(413)	22	35
36	Offset Misc. Revenue Med Surg & Food Sup.	(1,833)	10	36
37	Offset Misc. Revenue Non-Med Equip	(136)	6	37
38	Offset Misc. Revenue Incontinent	(1,285)	10	38
39	Offset Misc. Revenue Equip	(14)	10	39
40	Offset Misc. Revenue Other	(11)	21	40
41	Capitalize repairs & Maintenance & Equipment	(10,152)	10	41
42	Capitalize repairs & Maintenance & Equipment	(9,586)	6	42
43	Depreciation/Amort LHI	3,921	30	43
44	Depreciation/Amort MME	6,697	30	44
45	Current Year Depreciation Audit Adjustments LHI	(2,909)	30	45
46	Offset Outpatient Physical Therapy Revenue	(148,845)	10a	46
47	Offset Outpatient Occupational Therapy Revenue	(45,126)	10a	47
48	Offset Outpatient Speech Therapy Revenue	(2,483)	10a	48
49	Total	(261,468)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896 Report Period Beginning:

01/01/2016

Ending:

12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	20	0	0	0	0	0	0	0	0	0	0	20	1
2	Food Purchase	(3,233)	0	0	0	0	0	0	0	0	0	0	(3,233)	2
3	Housekeeping	(233)	0	0	0	0	0	0	0	0	0	0	(233)	3
4	Laundry	(439)	0	0	0	0	0	0	0	0	0	0	(439)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(12,226)	0	0	0	0	0	0	0	0	0	0	(12,226)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,111)	0	0	0	0	0	0	0	0	0	0	(16,111)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,825)	1,953	0	0	0	0	0	0	0	0	0	(10,872)	10
10a	Therapy	(196,419)	26,598	0	0	0	0	0	0	0	0	0	(169,821)	10a
11	Activities	300	0	0	0	0	0	0	0	0	0	0	300	11
12	Social Services	288	0	0	0	0	0	0	0	0	0	0	288	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,458)	0	0	0	0	0	0	0	0	0	0	(3,458)	14
15	Other (specify):*	0	(6,836)	0	0	0	0	0	0	0	0	0	(6,836)	15
16	TOTAL Health Care and Programs	(212,114)	21,715	0	0	0	0	0	0	0	0	0	(190,399)	16
	C. General Administration													
17	Administrative	(1,285)	(131,950)	0	0	0	0	0	0	0	0	0	(133,235)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,438)	0	0	0	0	0	0	0	0	0	0	(2,438)	19
20	Fees, Subscriptions & Promotions	(33,880)	0	0	0	0	0	0	0	0	0	0	(33,880)	20
21	Clerical & General Office Expenses	(21,749)	(1,395)	0	0	0	0	0	0	0	0	0	(23,144)	21
22	Employee Benefits & Payroll Taxes	1,477	95	0	0	0	0	0	0	0	0	0	1,572	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(258,734)	0	8,831	0	0	0	0	0	0	0	0	(249,903)	27
28	TOTAL General Administration	(319,209)	(133,250)	8,831	0	0	0	0	0	0	0	0	(443,628)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(547,434)	(111,535)	8,831	0	0	0	0	0	0	0	0	(650,138)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	7,709	0	52,592	0	0	0	0	0	0	0	0	60,301	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	339,557	0	0	0	0	0	0	0	0	339,557	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(820,800)	0	0	0	0	0	0	0	0	(820,800)	34
35	Rent-Equipment & Vehicles	309	0	0	0	0	0	0	0	0	0	0	309	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,018	0	(428,651)	0	0	0	0	0	0	0	0	(420,633)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,883)	(74,594)	0	0	0	0	0	0	0	0	0	(89,477)	43
44	TOTAL Special Cost Centers	(14,883)	(74,594)	0	0	0	0	0	0	0	0	0	(89,477)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(554,299)	(186,129)	(419,820)	0	0	0	0	0	0	0	0	(1,160,248)	45

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, LLC	Birmingham	Pharmacy
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Tara Therapy, LLC	Orchard Park	Therapy
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare Solutions, LLC	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	White Hall Property Company, LLC	White Hall	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 N. H. Associates, LLC	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Group, LLC	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/b/a Tara Cares	Orchard Park	Support Office

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	21 Wireless Access Points License Fee	\$ 2,464	Raimax Healthcare Solutions Group, LLC	0.00%	\$ 1,069	\$ (1,395)	1
2	V	15 Wireless Access Points License Fee	605	Raimax Healthcare Solutions Group, LLC	0.00%		(605)	2
3	V	15 Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	(891)	(4,491)	3
4	V	10 Pharmacy Consulting Services	25,704	Tara Pharmacy SE, LLC	0.00%	27,657	1,953	4
5	V	43 FluVac/Prescription Drug-Residents	217,914	Tara Pharmacy SE, LLC	0.00%	143,320	(74,594)	5
6	V	22 Hep B & TB Vaccines for Employees	2,414	Tara Pharmacy SE, LLC	0.00%	2,509	95	6
7	V	15 Misc. Sales & Delivery Charges	1,740	Tara Pharmacy SE, LLC	0.00%		(1,740)	7
8	V	10a Physical Therapy Fees	469,229	Tara Therapy, LLC	0.00%	482,631	13,402	8
9	V	10a Occupational Therapy Fees	374,568	Tara Therapy, LLC	0.00%	354,636	(19,932)	9
10	V	10a Speech Therapy Fees	134,722	Tara Therapy, LLC	0.00%	167,850	33,128	10
11	V	17 Administrative Services Costs	387,132	Aurora Cares, LLC d/b/a Tara Cares	0.00%	255,182	(131,950)	11
12	V							12
13	V							13
14	Total		\$ 1,620,092			\$ 1,433,963	\$ * (186,129)	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 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)	
15	V	34 Rent	\$ 820,800	White Hall Property Company, LLC	0.00%	\$	\$ (820,800)	15
16	V	30 Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	35,605	35,605	16
17	V	30 Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	11,061	11,061	17
18	V	30 Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	5,926	5,926	18
19	V	27 Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	8,831	8,831	19
20	V	32 Interest -Capital /LongTerm		White Hall Property Company, LLC	0.00%	210,174	210,174	20
21	V	32 Interest - Working CapSwap		White Hall Property Company, LLC	0.00%	129,383	129,383	21
22	V	1 Dietary Services	13,870	Scenic Nursing and Rehabilitation Center, LLC	0.00%	13,870		22
23	V	10 Nursing Services	225	Scenic Nursing and Rehabilitation Center, LLC	0.00%	225		23
24	V	10 Nursing Services	39,442	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	39,442		24
25	V	10 MDS Services	251	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	251		25
26	V	10 Nursing Services	860	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	860		26
27	V	12 Social Services	306	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	306		27
28	V	21 Clerical and General Office	87	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	87		28
29	V	6 Maintenance Services	204	Granite Nursing and Rehabilitation Center, LLC	0.00%	204		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		\$ 876,045			\$ 456,225	\$ * (419,820)	39

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			Jonesboro Nursing and Rehabilitation Center, LLC					1
2			Lake City Nursing and Rehabilitation Center, LLC					2
3			Mobile Nursing and Rehabilitation Center, LLC					3
4			Florence Nursing and Rehabilitation Center, LLC					4
5			Birmingham Nrs&Rehab Center East, LLC					5
6			Birmingham Nursing and Rehabilitation Center, LLC					6
7			Eight Mile Nursing and Rehabilitation Center, LLC					7
8			North Hill Nursing and Rehabilitation Center, LLC					8
9			Elba Nursing and Rehabilitation Center, LLC					9
10			Quince Nursing and Rehabilitation Center, LLC					10
11			Allenbrooke Nursing and Rehabilitation Center, LLC					11
12			Tupelo Nursing and Rehabilitation Center, LLC					12
13			Brandon Nursing and Rehabilitation Center, LLC					13
14			Lakeland Nursing and Rehabilitation Center, LLC					14
15			McComb Nursing and Rehabilitation Center, LLC					15
16			Cleveland Nursing and Rehabilitation Center, LLC					16
17			Chadwick Nursing and Rehabilitation Center, LLC					17
18			Manhattan Nursing and Rehabilitation Center, LLC					18
19			Ruleville Nursing and Rehabilitation Center, LLC					19
20			Farmerville Nursing and Rehabilitation Center, LLC					20
21			Bernice Nursing and Rehabilitation Center, LLC					21
22			Ruston Nursing and Rehabilitation Center, LLC					22
23			Natchitoches Nursing and Rehabilitation Center, LLC					23
24			Winnfield Nursing and Rehabilitation Center, LLC					24
25			Ringgold Nursing and Rehabilitation Center, LLC					25
26			Arcadia Nursing and Rehabilitation Center, LLC					26
27			Jena Nursing and Rehabilitation Center, LLC					27
28								28
29			** The above listed facilities are related by					29
30			common ownership					30

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	DTD HC, LLC	Owner		Owner	0	0	0.00		\$ 0	17	1
2	D & N, LLC	Owner		Owner	0	0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO		CFO & Co***		0.81	2.03	Fin/ Adm. of TC	6,171	17	3
4		for Tara Cares		for Tara Cares							4
5	Norbert A. Bennett	CEO for Tara Cares		CEO for T***		0.81	2.03	Fin/ Adm. of TC	6,171	17	5
6											6
7	Suzette Wilson	Vice President		Vice Presic***		0.81	2.03	VP of TC	5,512	17	7
8											8
9											9
10	*** Compensation paid only through Support Office and allocated share reported in column 7.										10
11											11
12											12
13								TOTAL	\$ 17,854		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 **White Hall Nsg & Rehab Ctr**# **0046896**

Report Period Beginning:

01/01/2016Ending: **2/31/2016**

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 **Aurora Cares, LLC d/b/a Tara Cares**
 Street Address **PO Box 428**
 City / State / Zip Code **Orchard Park, NY 14127**
 Phone Number **(716)662-4955**
 Fax Number **(716)662-2529**

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	Administrative Services Costs	Total Costs	393,631,114	40	\$ 327,613	\$ 248,771	7,830,099	\$ 6,518
2	5	Administrative Services Costs	Days	1,573,569	36	39,084	0	39,674	986
3	6	Administrative Services Costs	Days	1,573,569	36	73,458	0	39,674	1,852
4	10	Administrative Services Costs	Total Costs	393,631,114	40	2,792,167	2,199,184	7,830,099	55,526
5	17	Administrative Services Costs	Days	1,573,569	36	5,935,931	5,935,931	39,674	149,660
6	19	Administrative Services Costs	Days	1,573,569	36	10,996	0	39,674	277
7	20	Administrative Services Costs	Days	1,573,569	36	13,064	0	39,674	329
8	21	Administrative Services Costs	Days	1,573,569	36	280,112	0	39,674	7,064
9	22	Administrative Services Costs	Days	1,573,569	36	874,230	0	39,674	22,042
10	24	Administrative Services Costs	Days	1,573,569	36	142,490	0	39,674	3,593
11	26	Administrative Services Costs	Days	1,573,569	36	5,764	0	39,674	145
12	27	Administrative Services Costs	Days	1,573,569	36	92,390	0	39,674	2,330
13	30	Administrative Services Costs	Days	1,573,569	36	83,854	0	39,674	2,115
14	31	Administrative Services Costs	Days	1,573,569	36	10,324	0	39,674	260
15	33	Administrative Services Costs	Days	1,573,569	36	30,404	0	39,674	767
16	34	Administrative Services Costs	Days	1,573,569	36	66,534	0	39,674	1,677
17	35	Administrative Services Costs	Days	1,573,569	36	1,606	0	39,674	41
18									
19									
20	NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								
21	Aurora Cares, LLC has no ownership interest and does not manage the reporting facilitiy. Therefore, Aurora Cares, LLC is not								
22	considered a Home Office by CMS and as defined in 42CFR 421.404.								
23									
24									
25	TOTALS				\$ 10,780,021	\$ 8,383,886		\$ 255,182	

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	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	First Niagara Bank			Land and Building	\$27,885.00	2/28/14	\$ 6,368,179	\$ 5,773,085	2/28/34	LIBOR PI	\$ 247,614	1	
2	First Niagara Bank			Land and Building	\$11,318.00	2/28/14	2,706,821	2,333,327	03/01/19	LIBOR PLUS	91,943	2	
3												3	
4												4	
5												5	
	Working Capital												
6	None											6	
7												7	
8												8	
9	TOTAL Facility Related				\$39,203.00		\$ 9,075,000	\$ 8,106,412			\$ 339,557	9	
	B. Non-Facility Related*												
10	None											10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,075,000	\$ 8,106,412			\$ 339,557	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- 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.)

Facility Name & ID Number **White Hall Nsg & Rehab Ctr**# **0046896** Report Period Beginning: **01/01/2016** Ending: **12/31/2016****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	87,400	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.)				\$	75,672	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(11,728)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	160,760	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.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6				\$	149,032	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2011	75,736	8
	2012	81,020	9
	2013	79,245	10
	2014	75,398	11
	2015	75,672	12

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION\$ 16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nsg & Rehab Ctr COUNTY Greene
 FACILITY IDPH LICENSE NUMBER 0046896
 CONTACT PERSON REGARDING THIS REPORT Gary F. Eye
 TELEPHONE (716) 662-4955, ext. 392 FAX #: (716) 662-4468

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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>11-53-34-400-002</u>	<u>620 W. Bridgeport</u>	\$ <u>75,672.48</u>	\$ <u>75,672.48</u>
2. _____	<u>3W JC 536</u>	\$ _____	\$ _____
3. _____	<u>34-12-12</u>	\$ _____	\$ _____
4. _____	<u>PT N MID PT E1/2 SE</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>75,672.48</u></u>	\$ <u><u>75,672.48</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 White Hall Nsg & Rehab Ctr

0046896

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,655 B. General Construction Type: Exterior Brick Frame Metal Number of Stories OneC. 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).

NoneF. 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: 63,995 2. Number of Years Over Which it is Being Amortized: 5 years (60 months)3. Current Period Amortization: Included in Schedule VII B Ln 1-8 4. Dates Incurred: Various and on the books of related entitiesNature of Costs: Inc. Capitalized Pre-Opening Salaries, Benefits&OtherCostsIncurred2009&2010. AllocatedViaRelatedOrgCost& ReportedSchVII B
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Long Term Care</u>	<u>209,829</u>	<u>2011</u>	<u>\$ 19,707</u>	1
2					2
3	TOTALS	<u>209,829</u>		<u>\$ 19,707</u>	3

Facility Name & ID Number White Hall Nsg & Rehab Ctr

0046896

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	119	2011	1972	\$ 237,024	\$ 5,926	40	\$ 5,926		\$ 32,591
5									
6									
7									
8									
	Improvement Type**								
9	Alumalite Sign	2005		797		10			797
10	Generator Repairs, capitalized for Medicaid	2005		2,270		3			2,270
11	Auto Cad Design for Fire Alarm System	2006		1,080	54	10	54		1,080
12	Sign Pillars w/ Lighting	2006		8,975	449	10	449		8,975
13	Window Treatment	2006		13,663	683	10	683		13,663
14	Shower Room Renovations	2006		46,015	3,834	12	3,834		40,263
15	Measure & Install Blinds in Facility	2006		10,998		5			10,998
16	Handrail and Background Staining	2006		14,880	1,240	12	1,240		13,020
17	Electrical Wiring (lighting & smoke detectors)	2006		23,000	1,917	12	1,917		20,125
18	Sprinkler System Repairs, capitalized for Medicaid	2006		3,194		3			3,194
19	Installation of Data Outlet Recepticles for Medicaid	2007		4,160		3			4,160
20	Dry Wall - Entire Building	2007		10,329	1,033	10	1,033		9,813
21	3 Electric Water Heaters	2007		2,534	253	10	253		2,407
22	Phone System	2007		10,021	1,002	10	1,002		8,517
23	Dish Machine	2007		4,000	400	10	400		3,400
24	Smoke Detectors	2008		3,125	312	10	312		2,656
25	Window replacement (windows, sills, trim)	2009		40,527	4,503	9	4,503		33,773
26	Nurse Station	2009		56,951	6,328	9	6,328		47,459
27	Tile Floor	2009		13,887	1,543	9	1,543		11,572
28	A/C Roof Unit Repair - capitalized for Medicaid	2009		2,948		3			2,948
29									
30									
31									
32									
33									
34									
35									
36									

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr

0046896

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 A/C Units (4)	2010	\$ 2,099	\$	5	\$	\$	\$ 2,099		37
38 A/C Units (3)	2010	1,626	203	8	203		1,321		38
39 Walk-In Freezer	2010	12,075	1,509	8	1,509		9,811		39
40 RepairsFromLightningStrike-capMcdREDUCED ON AUDIT	2010	8,790		3			8,790		40
41 Water Softener System	2011	4,233	605	7	605		3,326		41
42 A/C Unit (5)	2011	2,688	269	5	269		2,688		42
43 Window Replacement	2011	47,741	6,820	7	6,820		37,511		43
44 Parking Lot Repairs capitalized for Medicaid	2011	2,600		3			2,600		44
45 A/C Units (4)	2012	2,372	474	5	474		2,134		45
46 Air Curtain	2012	721	48	15	48		216		46
47 Built-in AC Units (2)	2012	1,186	237	5	237		1,067		47
48 5-Ton AC Unit	2013	3,929	262	15	262		917		48
49 2 Built in AC Units	2013	1,258	252	5	252		881		49
50 Cabling - Wireless Upgrade	2013	3,539	177	20	177		619		50
51 Replaced Floor Tile in Dining Room and North Lounge	2013	17,016	1,702	10	1,702		5,956		51
52									52
53 AC Units - Built in (2)	2013	1,258	252	5	252		881		53
54 Flooring for Behavior Memory Unit	2014	29,355	2,935	10	2,935		7,339		54
55 A/C Unit 8.5 Ton Rooftop	2014	9,837	984	10	984		2,459		55
56 AC Units - Built in (18)	2014	12,680	2,536	5	2,536		6,340		56
57 AC Units - Built in (4)	2014	2,593	519	5	519		1,297		57
58 Smoker's Gazebo (1)	2014	2,693	269	10	269		673		58
59 18 Bed / Therapy Expansion - IDPH # L3619	2015	3,760,340	150,414	25	150,414		225,620		59
60 Replace 1,000 sq feet of asphalt pavement- capitalized for Medicaid	2015	3,981	498	8	498		746		60
61 Labor and Materials to rebuild concrete pad for dumpster - Cap fo	2016	2,975	99	15	99		99		61
62									62
63 Note: See additional building improvements made by former		626,406	22,707		22,707		570,661		63
64 property owner Healthcare REIT, Inc. on supplemental									64
65 schedule included as page 24 of the cost report.									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 5,074,369	\$ 223,248		\$ 223,248	\$	\$ 1,169,732		70

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

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	\$ 458,268	\$ 74,235	\$ 74,235		Various	\$ 182,017	71
72	Current Year Purchases	16,763	1,767	1,767		Various	1,767	72
73	Fully Depreciated Assets	174,944	1,645	1,645		Various	174,947	73
74								74
75	TOTALS	\$ 649,975	\$ 77,647	\$ 77,647			\$ 358,731	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	Long Term Care	2009 Ford E250 Extended	2009	\$ 36,675				5	\$ 36,675	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			\$ 36,675					\$ 36,675	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)	\$ 5,780,726	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,895	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,895	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,565,138	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

☐ YES ☐ NO

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

**

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 41,516

Description: see separate schedule

(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

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. /2017 \$ _____

13. /2018 \$ _____

14. /2019 \$ _____

* 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.

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016
 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	☒ YES ☐ NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM ☐	IN-HOUSE PROGRAM ☐
		IN OTHER FACILITY ☐	IN OTHER FACILITY ☒
	COMMUNITY COLLEGE ☒	HOURS PER CNA <u>48</u>	
	HOURS PER CNA <u>88</u>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 916	\$	\$ 916
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	\$	\$ 916	\$	\$ 916
10	SUM OF line 9, col. 1 and 2 (e)	\$ 916			

C. CONTRACTUAL INCOME

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

\$ 0

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	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		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

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	\$ 21,314	\$	1
2 Cash-Patient Deposits	39,770		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,867,041		3
4 Supply Inventory (priced at cost)	5,983		4
5 Short-Term Investments			5
6 Prepaid Insurance	5,082		6
7 Other Prepaid Expenses	10,173		7
8 Accounts Receivable (owners or related parties)	(323,713)		8
9 Other(specify): <u>Non Resident A/R (see TB)</u>	65,077		9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 1,690,727	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	3,833,611		15
16 Equipment, at Historical Cost	381,445		16
17 Accumulated Depreciation (book methods)	(402,360)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	(3,062)		21
22 Other Long-Term Assets (specify):	1,758		22
23 Other(specify): <u>Deposits Long Term</u>			23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 3,811,392	\$	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 5,502,119	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 96,761	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	43,636		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	293,802		30
31 Accrued Taxes Payable (excluding real estate taxes)	45,188		31
32 Accrued Real Estate Taxes(Sch.IX-B)	160,760		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Employee Benefits Payable</u>	37,953		36
37 <u>Accrued Expenses</u>	290,897		37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 968,997	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 968,997	\$	46
TOTAL EQUITY(page 18, line 24)	\$ 4,533,122	\$	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 5,502,119	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,495,457	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,495,457	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(302,909)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	625,374	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(284,800)	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)	\$ 37,665	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)	\$ 4,533,122	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **White Hall Nsg & Rehab Ctr**# **0046896**Report Period Beginning: **01/01/2016**Ending: **12/31/2016****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	\$ 6,295,548	1
2	Discounts and Allowances for all Levels	718,813	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,014,361	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	196,454	5
6	Therapy	610,900	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 807,354	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	2,945	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,685	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,472	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,102	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	73,314	28
28a	Purchase Discounts & Misc Revenue	7,191	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 80,505	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,914,370	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,035,346	31
32	Health Care	3,609,546	32
33	General Administration	1,798,952	33
	B. Capital Expense		
34	Ownership	1,230,090	34
	C. Ancillary Expense		
35	Special Cost Centers	263,336	35
36	Provider Participation Fee	280,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,217,279	40
41	Income before Income Taxes (line 30 minus line 40)**	(302,909)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (302,909)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,382,682	44
45	Private Pay - Net Inpatient Revenue	1,290,275	45
46	Medicare - Net Inpatient Revenue	2,322,404	46
47	Other-(specify) <u>Hospice</u>	19,000	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,014,361	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? see attached 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.

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	1,992	2,080	\$ 68,291	\$ 32.83	1
2	Assistant Director of Nursing	984	1,033	23,369	22.62	2
3	Registered Nurses	8,625	9,660	252,377	26.13	3
4	Licensed Practical Nurses	31,862	34,618	743,270	21.47	4
5	CNAs & Orderlies	78,673	85,934	971,217	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,897	2,121	32,447	15.30	9
10	Activity Assistants	3,815	4,010	38,327	9.56	10
11	Social Service Workers	5,556	6,101	86,650	14.20	11
12	Dietician					12
13	Food Service Supervisor	1,797	1,966	28,296	14.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,233	5,721	52,130	9.11	15
16	Dishwashers	15,575	17,355	157,004	9.05	16
17	Maintenance Workers	3,667	4,021	54,374	13.52	17
18	Housekeepers	14,782	16,395	161,819	9.87	18
19	Laundry	6,257	6,753	62,335	9.23	19
20	Administrator	1,888	2,291	77,225	33.71	20
21	Assistant Administrator					21
22	Other Administrative	5,442	6,325	142,254	22.49	22
23	Office Manager	1,561	1,872	37,455	20.01	23
24	Clerical	2,070	2,176	24,683	11.34	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	3,448	3,683	50,218	13.64	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	96	96	881	9.18	33
34	TOTAL (lines 1 - 33)	195,220	214,211	\$ 3,064,622 *	\$ 14.31	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		\$	1-3	35
36	Medical Director	277	16,068	9-3	36
37	Medical Records Consultant	16	560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed/month	25,704	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,976	11-3	44
45	Social Service Consultant	32	1,989	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	357	\$ 46,297		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	117	4,335	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	117	\$ 4,335		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Lori McKinnon	Administrator	0	\$ 76,675	Workers' Compensation Insurance		\$ 78,441	IDPH License Fee		\$ 1,990
Christine Warcup	Administrator	0	550	Unemployment Compensation Insurance		47,076	Advertising: Employee Recruitment		7,256
Billye Titus	Administrator Asst	0	66,580	FICA Taxes		230,322	Health Care Worker Background Check		1,002
Melissa Eschbach, Leah Henson	Bus. Office Mgr	0	37,455	Employee Health Insurance		96,029	(Indicate # of checks performed <u>22</u>)		
Nancy Willenburg	HR/Payroll	0	36,506	Employee Meals			Patient Background Checks	<u>129</u>	1,290
Scott Phares, Christopher Cox	Admiss Director/Asst	0	39,169	Illinois Municipal Retirement Fund (IMRF)*			Facility Advertising		30,676
L.Henson,K. Schutz, C. Butler	Bus. Office Ast	0	24,682	Worker Compensation Safety Rec. Program		300	IL Health Care Association/Chamber/Econ I		8,004
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Benefits - Other		31,037	Non-allowHealthCareAssn/ChamberC		(3,178)
(List each licensed administrator separately.)			\$ 281,617	Employee Benefits - S Term Disability/Life		495	Admin License Renew		150
B. Administrative - Other				Employee Benefits - Hepatitis B Vaccination		496	Citrix License Renew/Fingerprinting/Facility		2,892
Description			Amount	Employee Benefits- Life Insurance (ER)		1,405	Less: Public Relations Expense	(	
Tara Cares Administrative Service Fee			\$ 387,132	Employee Benefits - Exchange,Tuition,Dental		5,737	Non-allowable advertising		(30,676)
				Employee Benefits - H.S.A. (ER)		4,560	Yellow page advertising	(	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 495,898	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,406
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 387,132	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description		Amount
C. Professional Services				None in allowable cost		\$	Out-of-State Travel		\$
Vendor/Payee	Type		Amount	(Column 8) of Schedule V					
Freed, Maxick & Battaglia	Accounting Fees		\$ 2,518				In-State Travel		25,064
Freed, Maxick & Battaglia	Tax Fees		2,438						
Various Legal Fees - See attached detailed listing			40,513				Seminar Expense		500
							Entertainment Expense	(	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 25,564
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(For legal fee disclosure, see page 39 of instructions)			\$ 45,469						

* Attach copy of IMRF notifications

**See instructions.

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 \$4,826 net of non-allowables
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,753 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedure 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 280,009
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes outpatient services 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 benefit on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,945
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
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? No Personal Use
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	<u>Improvements Made by Health Care REIT (covered by rent at outset</u>										
10	<u>of Change of Ownership):</u>										
11											11
12	<u>Ductwork</u>		2005		65,173	3,259		3,259		37,474	12
13	<u>EPDM Roof System</u>		2005		213,004					213,004	13
14	<u>Fire Alarm System</u>		2005		30,608					30,608	14
15	<u>Service Doors (2), Break Room Door (1)</u>		2005		4,650	358		358		4,114	15
16	<u>Drywall seven (7) rooms</u>		2005		1,983	153		153		1,754	16
17	<u>A/C Units</u>		2006		18,611					18,612	17
18	<u>Installation of Fire Alarm System</u>		2006		1,820	91		91		1,820	18
19	<u>Chair Rails</u>		2006		2,380	198		198		2,082	19
20	<u>Paint Ceilings in Resident Rooms</u>		2006		3,825					3,825	20
21	<u>Wall Repair and Painting of Facility</u>		2006		55,141					55,141	21
22	<u>A/C Unit 5 Ton</u>		2006		3,600	180		180		3,600	22
23	<u>Landscaping</u>		2006		9,979	499		499		9,979	23
24	<u>Sprinkler System</u>		2006		169,310	14,109		14,109		148,146	24
25	<u>Suspend Ceiling</u>		2006		46,322	3,860		3,860		40,502	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Total (lines 9 thru 35)				626,406	22,707		22,707		570,661	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