

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>620 W Bridgeport St</u> <u>White Hall</u> <u>62092</u>			
Number City Zip Code			
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		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Renee Klawon</u>		Telephone Number: <u>(716) 972-2305</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ <u>6/29/2021</u> (Date)	
		(Type or Print Name) <u>Jill Spurgeon</u>	
		(Title) <u>Executive Director</u>	
		Paid Preparer	
		(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 Center

0046896 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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>24,616</u>	<u>5,176</u>	<u>5,845</u>	<u>35,637</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>24,616</u>	<u>5,176</u>	<u>5,845</u>	<u>35,637</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.82%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

Outpatient Therapy

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 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/2005 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 4,865

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 1/1 to 12/31/20 Fiscal Year: 1/1 to 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number White Hall Nsg Rehab Center # 0046896 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	256,279	22,725	23,580	302,584		302,584	(1,378)	301,206			1
2	Food Purchase		225,680		225,680		225,680	(1,113)	224,567			2
3	Housekeeping	168,120	29,233		197,353		197,353		197,353			3
4	Laundry	72,228	43,658		115,886		115,886	(2)	115,884			4
5	Heat and Other Utilities			111,672	111,672		111,672		111,672			5
6	Maintenance	77,465	37,536	64,217	179,218		179,218	(1,378)	177,840			6
7	Other (specify):* see trial balance			31,530	31,530		31,530		31,530			7
8	TOTAL General Services	574,092	358,832	230,999	1,163,923		1,163,923	(3,871)	1,160,052			8
	B. Health Care and Programs											
9	Medical Director			16,680	16,680		16,680		16,680			9
10	Nursing and Medical Records	2,762,423	309,549	123,892	3,195,864		3,195,864	(20,376)	3,175,488			10
10a	Therapy		5,784	819,961	825,745		825,745	(12,083)	813,662			10a
11	Activities	74,548	8,408	998	83,954		83,954		83,954			11
12	Social Services	87,110	443	653	88,206		88,206		88,206			12
13	CNA Training			13,730	13,730		13,730		13,730			13
14	Program Transportation			26,416	26,416		26,416	(6,682)	19,734			14
15	Other (specify):* see trial balance			13,859	13,859		13,859	(3,547)	10,312			15
16	TOTAL Health Care and Programs	2,924,081	324,184	1,016,189	4,264,454		4,264,454	(42,688)	4,221,766			16
	C. General Administration											
17	Administrative	298,423		315,708	614,131		614,131	(2,038)	612,093			17
18	Directors Fees											18
19	Professional Services			62,482	62,482		62,482	(2,825)	59,657			19
20	Dues, Fees, Subscriptions & Promotions			57,050	57,050		57,050	(36,850)	20,200			20
21	Clerical & General Office Expenses	16,318	60,085	81,971	158,374		158,374	(26,107)	132,267			21
22	Employee Benefits & Payroll Taxes			636,927	636,927		636,927	(2,605)	634,322			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,147	13,147		13,147		13,147			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200,790	200,790		200,790	(2,600)	198,190			26
27	Other (specify):* see trial balance			73,506	73,506		73,506	4,031	77,537			27
28	TOTAL General Administration	314,741	60,085	1,441,581	1,816,407		1,816,407	(68,994)	1,747,413			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,812,914	743,101	2,688,769	7,244,784		7,244,784	(115,553)	7,129,231			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			190,533	190,533		190,533	20,346	210,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							172,305	172,305			32
33	Real Estate Taxes			185,701	185,701		185,701		185,701			33
34	Rent-Facility & Grounds			820,800	820,800		820,800	(820,800)				34
35	Rent-Equipment & Vehicles			108,771	108,771		108,771		108,771			35
36	Other (specify):* Off-site Storage			3,945	3,945		3,945		3,945			36
37	TOTAL Ownership			1,309,750	1,309,750		1,309,750	(628,149)	681,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,409	252,409		252,409		252,409			42
43	Other (specify):* see Trial Balance			436,500	436,500		436,500	(254,113)	182,387			43
44	TOTAL Special Cost Centers			688,909	688,909		688,909	(254,113)	434,796			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,812,914	743,101	4,687,428	9,243,443		9,243,443	(997,815)	8,245,628			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(964)	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	(25)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	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	(2,260)	21		18
19	Entertainment				19
20	Contributions	(1,126)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,002)	27		24
25	Fund Raising, Advertising and Promotional	(34,411)	20		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	(356,879)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (400,816)		\$	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 Amount	2 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)	(596,999)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (596,999)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (997,815)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues & Subscriptions	\$ (2,354)	20	1
2	Remove Non-allowable Admin Dues & Subscriptions	(35)	20	2
3	Remove Non-allowable Admiss Other Supplies	(7,836)	21	3
4	Remove Non-allowable Insurance Costs	(2,600)	26	4
5	Remove Non-allowable Admin Other Supplies	(2,132)	21	5
6	Remove Non-allow Admin-TaxCreditSvcs(WOTC)	(780)	21	6
7	Remove Non-allowable Finance Charges	(1,627)	21	7
8	Remove Non-allow NRS Admin-Res Transportation	(6,682)	14	8
9	Remove Non-allowable Admin - Legal Fees	(305)	19	9
10	Remove Non Allowable Human Res Background Checks	(50)	20	10
11	Remove Non Allowable - BO- Tax Preparation Fees	(2,520)	19	11
12	Remove Non-allowable IV Prescription Drugs Costs	(74,145)	43	12
13	Remove Non-allowable Prior Year Costs	(107,078)	43	13
14	Offset Misc. Revenue	(2,969)	10	14
15	Offset Misc. Revenue	(59)	10	15
16	Offset Misc. Revenue	(801)	10	16
17	Offset Misc. Revenue	(2)	10	17
18	Offset Misc. Revenue	(2)	4	18
19	Offset Misc. Revenue	(31)	21	19
20	Offset Misc. Revenue	(1,378)	10	20
21	Offset Misc. Revenue	(1,378)	1	21
22	Offset Misc. Revenue	(1,378)	6	22
23	Offset Misc. Revenue	(740)	10	23
24	Capitalize repairs & maintenance & equipment	(5,546)	10	24
25	Depreciation/Amortization LHI	4,322	30	25
26	Depreciation/Amortization MME	10,081	30	26
27	Current Year Depreciation Audit Adjustments LHI	(47)	30	27
28	Offset Outpatient Physical Therapy Revenue	(114,401)	10a	28
29	Offset Outpatient Occupational Therapy Revenue	(20,044)	10a	29
30	Offset Outpatient Speech Therapy Revenue	(1,968)	10a	30
31	Remove Non-allowable EE Benefit - EE Relocation	(2,469)	22	31
32	Remove Non-allowable Admin Other	(9,800)	21	32
33	Remove Non-allowable Admin Awards/Gifts	(125)	21	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	(356,879)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,378)	0	0	0	0	0	0	0	0	0	0	(1,378)	1
2	Food Purchase	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2)	0	0	0	0	0	0	0	0	0	0	(2)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,378)	0	0	0	0	0	0	0	0	0	0	(1,378)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,871)	0	0	0	0	0	0	0	0	0	0	(3,871)	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	(11,495)	(8,881)	0	0	0	0	0	0	0	0	0	(20,376)	10
10a	Therapy	(136,413)	124,330	0	0	0	0	0	0	0	0	0	(12,083)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(6,682)	0	0	0	0	0	0	0	0	0	0	(6,682)	14
15	Other (specify):*	0	(3,547)	0	0	0	0	0	0	0	0	0	(3,547)	15
16	TOTAL Health Care and Programs	(154,590)	111,902	0	0	0	0	0	0	0	0	0	(42,688)	16
	C. General Administration													
17	Administrative	0	(2,038)	0	0	0	0	0	0	0	0	0	(2,038)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,825)	0	0	0	0	0	0	0	0	0	0	(2,825)	19
20	Fees, Subscriptions & Promotions	(36,850)	0	0	0	0	0	0	0	0	0	0	(36,850)	20
21	Clerical & General Office Expenses	(24,616)	(1,491)	0	0	0	0	0	0	0	0	0	(26,107)	21
22	Employee Benefits & Payroll Taxes	(2,469)	(136)	0	0	0	0	0	0	0	0	0	(2,605)	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):*	(6,128)	0	10,159	0	0	0	0	0	0	0	0	4,031	27
28	TOTAL General Administration	(75,488)	(3,665)	10,159	0	0	0	0	0	0	0	0	(68,994)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(233,949)	108,237	10,159	0	0	0	0	0	0	0	0	(115,553)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nsg Rehab Center # 0046896 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	14,356	0	5,990	0	0	0	0	0	0	0	0	20,346	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	172,305	0	0	0	0	0	0	0	0	172,305	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	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	14,356	0	(642,505)	0	0	0	0	0	0	0	0	(628,149)	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):*	(181,223)	(72,890)	0	0	0	0	0	0	0	0	0	(254,113)	43
44	TOTAL Special Cost Centers	(181,223)	(72,890)	0	0	0	0	0	0	0	0	0	(254,113)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(400,816)	35,347	(632,346)	0	0	0	0	0	0	0	0	(997,815)	45

Facility Name & ID Number White Hall Nsg Rehab Center# 0046896Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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, LI	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 Sol	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	White Hall Property C	White Hall	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 N. H. Associates,	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Grou	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/	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	17	Administrative Services Costs	\$ 315,708	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 313,670	\$ (2,038)	1
2	V	15	Wireless Access Points License Fee	1,582	RAImax Healthcare Solutions Group, LLC	0.00%	1,344	(238)	2
3	V	15	Patient Care Software	3,600	RAImax Healthcare Solutions Group, LLC	0.00%	291	(3,309)	3
4	V	21	Wireless Access Points License Fee		RAImax Healthcare Solutions Group, LLC	0.00%	485	485	4
5	V	21	Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(1,976)	(1,976)	5
6	V	10	Pharmacy Consulting Services	23,919	Tara Pharmacy SE, LLC	0.00%	15,038	(8,881)	6
7	V	43	Flu Vac/Prescription Drug- Residents	211,183	Tara Pharmacy SE, LLC	0.00%	138,293	(72,890)	7
8	V	22	Vaccines for Employees	2,134	Tara Pharmacy SE, LLC	0.00%	1,998	(136)	8
9	V	10a	Physical Therapy Fees	380,080	Tara Therapy, LLC	0.00%	446,891	66,811	9
10	V	10a	Occupational Therapy Fees	304,077	Tara Therapy, LLC	0.00%	293,137	(10,940)	10
11	V	10a	Speech Therapy Fees	131,004	Tara Therapy, LLC	0.00%	199,463	68,459	11
12	V								12
13	V								13
14	Total			\$ 1,373,287			\$ 1,408,634	\$ * 35,347	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.

☒ X

 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	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%	37	37	16
17	V	30	Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	27	27	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%	10,159	10,159	19
20	V	32	Interest -Capital/Long-Term Debt		White Hall Property Company, LLC	0.00%	106,631	106,631	20
21	V	32	Interest - SWAP		White Hall Property Company, LLC	0.00%	65,674	65,674	21
22	V	10	Nursing LPN Services	3,202	Riverside Nursing and Rehabilitation Center LLC	0.00%	3,202		22
23	V	1	Dietary Services	15,928	Scenic Nursing and Rehabilitation Center LLC	0.00%	15,928		23
24	V	6	Plant Operations	212	Stearns Nursing and Rehabilitation Center LLC	0.00%	212		24
25	V	1	Dietary Services	929	Stearns Nursing and Rehabilitation Center LLC	0.00%	929		25
26	V	10	MDS Coordinator Services	556	Calhoun Nursing and Rehabilitation Center LLC	0.00%	556		26
27	V	10	Nursing LPN Services	258	Calhoun Nursing and Rehabilitation Center LLC	0.00%	258		27
28	V	10	Director of Nursing Services	712	Calhoun Nursing and Rehabilitation Center LLC	0.00%	712		28
29	V	10	Restorative Nursing	81,446	Tara Therapy, LLC	0.00%	81,446		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			\$ 924,043			\$ 291,697	\$ * (632,346)	39

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

Facility Name & ID Number

White Hall Nsg Rehab Center

0046896

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

Facility Name & ID Number White Hall Nsg Rehab Center # 0046896 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		50.00		0	0.00		\$ 0	17	1
2	D & N, LLC	Owner		50.00		0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.8	2.00	Fin/ Adm. of TC	6,518	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.8	2.00	Fin/ Adm. of TC	6,518	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin	0.00	***	0.8	2.00	VP of TC	5,126	17	7
8			of Tara Cares								8
9	Christopher Denz	Vice President	Tara Cares	0.00	***	0.8	2.00	VP of TC	1,551	17	9
10											10
11	*** Compensation paid only through Support Office and allocated share reported in column 7.										11
12											12
13								TOTAL	\$ 19,713		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 Center# 0046896

Report Period Beginning:

01/01/2020Ending: 2/31/2020

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	39	\$ 387,083	\$ 294,025	8,926,104	\$ 8,461	1
2	3	Administrative Services Costs	Days	36	1,807	0	35,614	44	2
3	5	Administrative Services Costs	Days	36	28,542	0	35,614	688	3
4	6	Administrative Services Costs	Days	36	231,425	103,937	35,614	5,585	4
5	10	Administrative Services Costs	Total Costs	39	2,939,493	2,298,115	8,926,104	64,252	5
6	17	Administrative Services Costs	Days	36	7,181,342	7,181,342	35,614	173,332	6
7	19	Administrative Services Costs	Days	36	106,116	0	35,614	2,561	7
8	20	Administrative Services Costs	Days	36	152,019	0	35,614	3,668	8
9	21	Administrative Services Costs	Days	36	461,972	0	35,614	11,149	9
10	22	Administrative Services Costs	Days	36	1,411,377	0	35,614	34,065	10
11	24	Administrative Services Costs	Days	36	31,941	0	35,614	771	11
12	26	Administrative Services Costs	Days	36	5,217	0	35,614	126	12
13	27	Administrative Services Costs	Days	36	133,240	0	35,614	3,216	13
14	30	Administrative Services Costs	Days	36	96,883	0	35,614	2,338	14
15	33	Administrative Services Costs	Days	36	35,384	0	35,614	854	15
16	34	Administrative Services Costs	Days	36	103,471	0	35,614	2,498	16
17	35	Administrative Services Costs	Days	36	2,577	0	35,614	62	17
18									18
19									19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.							20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not							21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.							22
23									23
24									24
25	TOTALS				\$ 13,309,889	\$ 9,877,419		\$ 313,670	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		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	M&T Bank		X	Land and Building	\$24,095.00	8/30/18	\$ 4,335,000	\$ 3,660,340	9/1/23	Libor plus	\$ 172,305	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$24,095.00		\$ 4,335,000	\$ 3,660,340			\$ 172,305	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,335,000	\$ 3,660,340			\$ 172,305	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

[illegible]

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nsg Rehab Center COUNTY Greene

FACILITY IDPH LICENSE NUMBER 0046896

CONTACT PERSON REGARDING THIS REPORT Renee Klawon

TELEPHONE (716) 972-2305 FAX #: (716) 972-0338

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(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>179,461.32</u>	\$ <u>179,431.32</u>
2. <u></u>	<u>3W JC 536</u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u>34-12-12</u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u>PT N MID PT E1/2 SE</u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>179,461.32</u></u>	\$ <u><u>179,431.32</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 42,655

B. General Construction Type: Exterior BrickFrame MetalNumber of Stories One

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	209,829	2011	\$ 19,707	1
2					2
3	TOTALS	209,829		\$ 19,707	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	119		2011	1972	\$ 237,024	\$ 5,925	40	\$ 5,925		\$ 56,292
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		10			1,080
12	Sign Pillars w/ Lighting			2006	8,975		10			8,975
13	Window Treatment			2006	13,663		10			13,663
14	Shower Room Renovations			2006	46,015		12			46,015
15	Measure & Install Blinds in Facility			2006	10,998		5			10,998
16	Handrail and Background Staining			2006	14,880		12			14,880
17	Electrical Wiring (lighting & smoke detectors)			2006	23,000		12			23,000
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		10			10,329
21	3 Electric Water Heaters			2007	2,534		10			2,534
22	Phone System REDUCED ON AUDIT			2007	10,021		10			10,021
23	Dish Machine REDUCED ON AUDIT			2007	4,000		10			4,000
24	Smoke Detectors			2008	3,125		10			3,125
25	Window replacement (windows, sills, trim)			2009	40,527		9			40,527
26	Nurse Station			2009	56,951		9			56,951
27	Tile Floor			2009	13,887		9			13,887
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.

**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 White Hall Nsg Rehab Center

0046896

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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		8			1,626	38
39	Walk-In Freezer	2010	12,075		8			12,075	39
40	RepairsFromLightningStrike-capMc	2010	8,790		3			8,790	40
41	Water Softener System	2011	4,233		7			4,233	41
42	A/C Unit (5)	2011	2,688		5			2,688	42
43	Window Replacement	2011	47,741		7			47,741	43
44	Parking Lot Repairs capitalized for Medicaid	2011	2,600		3			2,600	44
45	A/C Units (4)	2012	2,372		5			2,372	45
46	Air Curtain	2012	721	48	15	48		408	46
47	Built-in AC Units (2)	2012	1,186		5			1,186	47
48	5-Ton AC Unit	2013	3,929	262	15	262		1,964	48
49	2 Built in AC Units	2013	1,258		5			1,258	49
50	Cabling - Wireless Upgrade	2013	3,539	354	20	354		1,681	50
51	Replaced Floor Tile in Dining Room and North Lounge	2013	17,016	1,702	10	1,702		12,762	51
52									52
53	AC Units - Built in (2)	2013	1,258		5			1,258	53
54	Flooring for Behavior Memory Unit	2014	29,355	2,935	10	2,935		19,080	54
55	A/C Unit 8.5 Ton Rooftop	2014	9,837	984	10	984		6,395	55
56	AC Units - Built in (18)	2014	12,680		5			12,680	56
57	AC Units - Built in (4)	2014	2,593		5			2,593	57
58	Smoker's Gazebo (1)	2014	2,693	269	10	269		1,749	58
59	18 Bed / Therapy Expansion - IDPH # L3619	2015	3,760,340	150,414	25	150,414		827,275	59
60	Replace 1,000 sq feet of asphalt pavement- capitalized for Medicaid	2015	3,981	498	8	498		2,737	60
61	Labor and Materials to rebuild concrete pad for dumpster - Cap f	2016	2,975	198	15	198		892	61
62	Landscaping and planting flowers	2017	2,913	291	10	291		1,019	62
63	Gym Entry Door capitalized for Medicaid	2018	3,964	198	20	198		495	63
64	Generator Repairs capitalized for Medicaid	2018	11,046	2,209	5	2,209		5,523	64
65	Fire Alarm capitalized for Medicaid	2018	2,617	262	10	262		655	65
66									66
67	Note: See additional building improvements made by former		626,406	3,259		3,259		611,742	67
68	property owner Healthcare REIT, Inc. on supplemental								68
69	schedule included as page 23 of the cost report.								69
70	TOTAL (lines 4 thru 69)		\$ 5,094,909	\$ 169,808		\$ 169,808	\$	\$ 1,927,222	70

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

Facility Name & ID Number White Hall Nsg Rehab Center

0046896

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,094,909	\$ 169,808		\$ 169,808	\$	\$ 1,927,222	1
2	Wiring for entrance door	2019	3,967	397	10	397		595	2
3	AC Unit (RTU)	2020	8,850	443	10	443		443	3
4	Nursing Call System	2020	1,112	56	10	56		56	4
5	Exhaust Ventilation	2020	4,451	223	10	223		223	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,113,289	\$ 170,927		\$ 170,927	\$	\$ 1,928,539	34

**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	\$ 385,380	\$ 40,094	\$ 40,094	\$	Various	\$ 335,857	71
72	Current Year Purchases	19,878	1,541	1,541		Various	1,541	72
73	Fully Depreciated Assets	283,906	1,576	1,576		Various	283,906	73
74								74
75	TOTALS	\$ 689,164	\$ 43,211	\$ 43,211	\$		\$ 621,304	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	\$	\$	\$		\$ 36,675
77		Wheelchair Van							
78									
79									
80	TOTALS			\$ 36,675	\$	\$	\$		\$ 36,675

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	5,858,835
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	214,138
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	214,138
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,586,518

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	None	\$
93		
94		
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: \$ 122,689 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. /2021 \$

13. /2022 \$

14. /2023 \$

* 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.

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

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☒

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

Spring 2020 program suspended due to COVID-19 - tuition paid 4/15/2020

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$ 13,730	\$ 13,730
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	\$	\$	\$ 13,730	\$ 13,730
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	Spring 2020
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	#VALUE!

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 prescrpts							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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,114,058	\$	1
2	Cash-Patient Deposits	44,531		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	623,346		3
4	Supply Inventory (priced at)	11,017		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,596		6
7	Other Prepaid Expenses	10,937		7
8	Accounts Receivable (owners or related parties)	(87,561)		8
9	Other(specify): <u>Non-resident A/R-see TB</u>	13,577		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,740,501	\$	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 Cost	3,848,024		15
16	Equipment, at Historical Cost	395,777		16
17	Accumulated Depreciation (book methods)	(1,238,699)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(7,221)		21
22	Other Long-Term Assets (specify) <u>Deposits-Long Term</u>	2,675		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,000,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,741,057	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 114,938	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,849		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	251,867		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,453		31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,440		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>	97,457		36
37	<u>Accrued Expenses</u>	383,454		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,129,458	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,129,458	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,611,599	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,741,057	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,794,457	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,794,457	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	833,086	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	(15,944)	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)	\$ 817,142	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)	\$ 3,611,599	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **White Hall Nsg Rehab Center**# **0046896**Report Period Beginning: **01/01/2020**Ending: **12/31/2020****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	\$ 6,386,449	1
2	Discounts and Allowances for all Levels	1,103,468	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,489,917	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	136,413	5
6	Therapy	633,904	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 770,317	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	964	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,430	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	97	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,168	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,659	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,631	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,631	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	1,649	28
28a	Federal & State COVID Funds / Misc Revenues	1,795,356	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,797,005	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,076,529	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,163,923	31
32	Health Care	4,264,454	32
33	General Administration	1,816,407	33
	B. Capital Expense		
34	Ownership	1,309,750	34
	C. Ancillary Expense		
35	Special Cost Centers	688,909	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,243,443	40
41	Income before Income Taxes (line 30 minus line 40)**	833,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 833,086	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,987,626	44
45	Private Pay - Net Inpatient Revenue	836,645	45
46	Medicare - Net Inpatient Revenue	2,401,682	46
47	Other-(specify) Hospice	72,000	47
48	Other-(specify) Medicare HMO	191,964	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,489,917	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? [see Pg 19 note](#) 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	1,904	2,209	\$ 88,478	\$ 40.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,832	18,479	584,459	31.63	3
4	Licensed Practical Nurses	25,140	27,028	853,660	31.58	4
5	CNAs & Orderlies	67,573	73,981	1,176,498	15.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,610	2,064	32,640	15.81	9
10	Activity Assistants	3,135	3,515	41,908	11.92	10
11	Social Service Workers	4,781	5,524	87,110	15.77	11
12	Dietician					12
13	Food Service Supervisor	1,416	1,472	28,818	19.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,176	6,540	80,201	12.26	15
16	Dishwashers	12,569	13,875	147,260	10.61	16
17	Maintenance Workers	3,451	3,853	77,465	20.11	17
18	Housekeepers	12,867	15,156	168,120	11.09	18
19	Laundry	6,050	6,717	72,228	10.75	19
20	Administrator	2,096	2,372	88,140	37.16	20
21	Assistant Administrator					21
22	Other Administrative	3,504	3,976	104,087	26.18	22
23	Office Manager	1,855	2,115	44,804	21.18	23
24	Clerical	5,105	5,629	77,710	13.81	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	2,457	2,946	54,435	18.48	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	359	365	4,893	13.41	33
34	TOTAL (lines 1 - 33)	178,880	197,816	\$ 3,812,914 *	\$ 19.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	323	16,680	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	38	23,919	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	11	653	11-3	44
45	Social Service Consultant	11	653	12-3	45
46	Other(specify) Int Exec Director	70	8,391	27-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	453	\$ 50,296		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	36	\$ 2,526	10-3	50
51	Licensed Practical Nurses	99	5,962	10-3	51
52	Certified Nurse Assistants/Aides	127	5,311	10-3	52
53	TOTAL (lines 50 - 52)	262	\$ 13,799		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jacqueline Burke	Administrator	0	\$ 3,481
Cutina Dunaway	Administrator	0	24,403
Gina Graham	Administrator	0	7,638
Alysia Heinz	Administrator	0	52,618
Leah Henson/Kim Schutz/Melissa Nichols	Bus Off Mgr/Asst	0	106,196
Nancy Willenburg	HR/Payroll	0	45,107
Brian Elliot/Scot Phares	Admiss Director	0	58,980
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 298,423
B. Administrative - Other			
Description			Amount
Tara Cares Administrative Services Fee		\$	315,708
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 315,708
C. Professional Services			
Vendor/Payee	Type		Amount
Freed, Maxick & Battaglia	Accounting Fees	\$	2,772
Freed, Maxick & Battaglia	Tax Fees		2,520
Various Legal Fees - See attached detailed listing			57,190
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 62,482
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	67,607
Unemployment Compensation Insurance			20,102
FICA Taxes			284,569
Employee Health Insurance			238,001
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			0
Worker Compensation Safety Rec. Program			1,499
Employee Benefit - Holiday/Recognition			11,545
Employee Benefit - Short Term Disability			402
Employee Benefit - Employee Vaccinations			1,998
Employee Benefit - HSA ER/Tuition Reimb			8,202
Employee Benefit - Other Employee Benefits			35
Employee Benefit - Dental/Vission Ins (ER)			362
TOTAL (agree to Schedule V, line 22, col.8)			\$ 634,322
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
None in allowable cost (column 8) of Schedule V		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			10,745
Health Care Worker Background Check (Indicate # of checks performed 24)			291
Patient Background Checks	81		810
Facility Advertising			34,411
IL Health Care Assoc/Chamber of Comm			8,603
Non-allwHealthCare Assn/ChamberCo			(2,389)
Dept of Fin & Profess'l Reg License Fees			150
Less: Public Relations Expense		(	
Non-allowable advertising			(34,411)
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 20,200
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			13,147
Seminar Expense			
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	13,147

*** 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 \$6,214 net of non-allowables
- (3) Did the nursing home make political contributions or payments to a political action 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? 9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,871 Line 10-2
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 252,409
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 svcs 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 964
- (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	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Improvements Made by Health Care REIT (covered by rent at outset									9
10	of Change of Ownership):									10
11										11
12	Ductwork			2005	65,173	3,259	20	3,259		50,509
13	EPDM Roof System			2005	213,004		10			213,004
14	Fire Alarm System			2005	30,608		10			30,608
15	Service Doors (2), Break Room Door (1)			2005	4,650		13			4,650
16	Drywall seven (7) rooms			2005	1,983		13			1,983
17	A/C Units			2006	18,611		5			18,611
18	Installation of Fire Alarm System			2006	1,820		10			1,820
19	Chair Rails			2006	2,380		12			2,380
20	Paint Ceilings in Resident Rooms			2006	3,825		5			3,825
21	Wall Repair and Painting of Facility			2006	55,141		5			55,141
22	A/C Unit 5 Ton			2006	3,600		10			3,600
23	Landscaping			2006	9,979		10			9,979
24	Sprinkler System			2006	169,310		12			169,310
25	Suspend Ceiling			2006	46,322		12			46,322
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36					626,406	3,259		3,259		611,742

*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 White Hall Nursing and Rehabilitation Center, LLC 0046896

Report Period Beginning: 1/1/2020 **Ending:** 12/31/2020

XVII. INCOME STATEMENT

Page 19 Note

Line 41 Income before Income Taxes 833,086 **

Does this agree with taxable income(loss) per Federal Income Tax Return?

** The Tax Return has been extended with a due date after the cost report filing date. It is expected that the cost report income and tax return income will agree.