

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0005785

Facility Name: Resthove Home Whiteside Cnty

Address: 408 Maple Avenue Morrison 61270

County: Whiteside

Telephone Number: (815) 772 - 4021 Fax # (815) 755 - 4583

HFS ID Number:

Date of Initial License for Current Owners: 05/22/69

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501(c)(3)

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:Jeremy M. Brune, CPA

Telephone Number: (779) 875 - 3979

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/24 to 08/31/25 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.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Jill Smith

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title) Jeremy M. Brune, CPA CEO

(Firm Name & Address) Jeremy Brune & Associates, LLC 2508 Riverwalk Drive Plainfield, Illinois 60586

(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number

Resthave Home Whiteside Cnty

#

0005785

Report Period Beginning:

09/01/24

Ending:

08/31/25

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	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	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	1,420	7,413			10,228	2,528	1,953	23,542	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,420	7,413			10,228	2,528	1,953	23,542	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

92.14%

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)

Assisted Living

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

X

NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

X

NO

I. On what date did you start providing long term care at this location?

Date started

04/31/69

J. Was the facility purchased or leased after January 1, 1978?

YES

Date

NO

X

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

70

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

08/31/25

Fiscal Year:

08/31/25

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 09/01/24 Ending: 08/31/25

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	471,960	28,406	6,407	506,773		506,773	(185,630)	321,143			1
2	Food Purchase		349,092		349,092		349,092	(128,213)	220,879			2
3	Housekeeping	344,193	40,861		385,054		385,054	(68,256)	316,798			3
4	Laundry		14,021		14,021		14,021	(2,485)	11,536			4
5	Heat and Other Utilities			273,488	273,488		273,488	(160,573)	112,915			5
6	Maintenance	139,221	24,842	92,576	256,639		256,639	(126,690)	129,949			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	955,374	457,222	372,471	1,785,067		1,785,067	(671,847)	1,113,220			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,867,841	162,577	767,370	3,797,788		3,797,788	(697,184)	3,100,604			10
10a	Therapy											10a
11	Activities	145,627	8,738	13,952	168,317		168,317	(12,839)	155,478			11
12	Social Services	108,024	698	2,088	110,810		110,810	(19,227)	91,583			12
13	CNA Training											13
14	Program Transportation			10,336	10,336		10,336	(3,786)	6,550			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	3,121,492	172,013	811,746	4,105,251		4,105,251	(733,036)	3,372,215			16
	C. General Administration											
17	Administrative	106,823		240,000	346,823		346,823	(54,592)	292,231			17
18	Directors Fees											18
19	Professional Services			272,246	272,246		272,246	(62,622)	209,624			19
20	Dues, Fees, Subscriptions & Promotions			27,098	27,098		27,098	(7,333)	19,765			20
21	Clerical & General Office Expenses	283,416	16,866	103,838	404,120		404,120	(204,929)	199,191			21
22	Employee Benefits & Payroll Taxes			727,493	727,493		727,493		727,493			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,198	8,198		8,198	(3,215)	4,983			24
25	Other Admin. Staff Transportation			3,866	3,866		3,866	(3,479)	387			25
26	Insurance-Prop.Liab.Malpractice			123,197	123,197		123,197	(28,023)	95,174			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	390,239	16,866	1,505,936	1,913,041		1,913,041	(364,193)	1,548,848			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,467,105	646,101	2,690,153	7,803,359		7,803,359	(1,769,076)	6,034,283			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			499,491	499,491		499,491	(246,575)	252,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			325,293	325,293		325,293	(177,987)	147,306			32
33	Real Estate Taxes			80,236	80,236		80,236	(39,609)	40,627			33
34	Rent-Facility & Grounds			4,120	4,120		4,120	(2,034)	2,086			34
35	Rent-Equipment & Vehicles			24,770	24,770		24,770	(5,634)	19,136			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			933,910	933,910		933,910	(471,839)	462,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,485	525,786	612,271		612,271		612,271			39
40	Barber and Beauty Shops			18,714	18,714		18,714		18,714			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			406,310	406,310		406,310		406,310			42
43	Other (specify):* See Supplemental	61,776	13,083	51,043	125,902		125,902	(125,902)				43
44	TOTAL Special Cost Centers	61,776	99,568	1,001,853	1,163,197		1,163,197	(125,902)	1,037,295			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,528,881	745,669	4,625,916	9,900,466		9,900,466	(2,366,817)	7,533,649			45

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

Resthave Home of Whiteside County, Inc.
Medicaid Cost Report
09/01/24 - 08/31/25

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 43 - Other Special Cost Centers								
Marketing		61,776		13,083		51,043		125,902
								-
								-
								-
								-
								-
Sub-Total		61,776		13,083		51,043		125,902

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	(538)	02		4
5	Telephone, TV & Radio in Resident Rooms	(50,489)	05		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	(34,028)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(8,000)	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	(73,639)	21		24
25	Fund Raising, Advertising and Promotional	(125,902)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(2,074,221)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,366,817)		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,366,817)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (1,513)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Collections	(900)	19	3
4	Bank Charges	(2,768)	21	4
5	Interest Expense	(347)	32	5
6				6
7				7
8	AL Allocation			8
9	Dietary	(185,630)	01	9
10	Food	(127,675)	02	10
11	Housekeeping	(68,256)	03	11
12	Laundry	(2,485)	04	12
13	Utilities	(110,084)	05	13
14	Maintenance	(126,690)	06	14
15	Nursing	(697,184)	10	15
16	Activities	(12,839)	11	16
17	Social Services	(19,227)	12	17
18	Transportation	(3,786)	14	18
19	Administration	(54,592)	17	19
20	Professional Fees	(61,722)	19	20
21	Dues and Subscriptions	(5,820)	20	21
22	Office and Clerical	(120,522)	21	22
23	Travel and Seminar	(3,215)	24	23
24	Other Staff Transportation	(3,479)	25	24
25	Insurance	(28,023)	26	25
26	Depreciation	(246,575)	30	26
27	Interest	(143,612)	32	27
28	Real Estate Taxes	(39,609)	33	28
29	Rent - Facility and Grounds	(2,034)	34	29
30	Rent - Equipment and Vehicles	(5,634)	35	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,074,221)		49

Resthave Home of Whiteside County
Medicaid Cost Report
09/01/24 - 08/31/25

Page 5 - Non-Care Supplemental Allocation Schedule

Page 5 - Non-Care Supplemental Allocation Schedule			Direct Costs				Statistics			Expenses	
Description	Cost Center	Salary	Total Allow. Exp.	Nursing Home	Other	Expenses For Alloc.	Alloc. Method	Nursing Home	Other	Nursing Home	Other
Dietary	1	471,960	506,773	-	-	506,773	Meals Served	70,626	40,824	321,143	185,630
Food	2	-	348,554	-	-	348,554	Meals Served	70,626	40,824	220,879	127,675
Housekeeping	3	344,193	385,054	-	-	385,054	SQFT (1)	20,301	4,374	316,798	68,256
Laundry	4	-	14,021	-	-	14,021	SQFT (1)	20,301	4,374	11,536	2,485
Heat and Other Utilities	5	-	222,999	-	-	222,999	SQFT	20,301	19,792	112,915	110,084
Maintenance	6	139,221	256,639	-	-	256,639	SQFT	20,301	19,792	129,949	126,690
Other	7	-	-	-	-	-	Pat. Days	23,542	13,608	-	-
Medical Director	9	-	18,000	18,000	-	-	Dir. Staffing	70,096	14,716	18,000	-
Nursing and Medical Records	10	2,867,841	3,797,788	227,911	94,089	3,475,788	Dir. Staffing	70,096	14,716	3,100,604	697,184
Therapy	10a	-	-	-	-	-	Dir. Staffing	70,096	14,716	-	-
Activities	11	145,627	168,317	-	-	168,317	Pat. Days (1)	164,794	13,608	155,478	12,839
Social Services	12	108,024	110,810	-	-	110,810	Dir. Staffing	70,096	14,716	91,583	19,227
CNA Training	13	-	-	-	-	-	Dir. Staffing	70,096	14,716	-	-
Transportation	14	-	10,336	-	-	10,336	Pat. Days	23,542	13,608	6,550	3,786
Other	15	-	-	-	-	-	Pat. Days	23,542	13,608	-	-
Administrative	17	106,823	346,823	106,823	-	240,000	Net. Pat. Rev.	7,554,988	2,224,512	292,231	54,592
Directors Fees	18	-	-	-	-	-	N/A			-	-
Professional Fees	19	-	271,346	-	-	271,346	Net. Pat. Rev.	7,554,988	2,224,512	209,624	61,722
Dues and Subscriptions	20	-	25,585	-	-	25,585	Net. Pat. Rev.	7,554,988	2,224,512	19,765	5,820
Office and Clerical	21	283,416	319,713	-	61,872	257,841	Net. Pat. Rev.	7,554,988	2,224,512	199,191	120,522
Employee Benefits	22	-	727,493	-	-	727,493	Salaries	3,486,543	1,042,338	560,058	167,435
Inservice Training and Expense	23	-	-	-	-	-	Pat. Days	23,542	13,608	-	-
Travel and Seminar	24	-	8,198	-	1,100	7,098	Net. Pat. Rev.	7,554,988	2,224,512	4,983	3,215
Other Staff Transportation	25	-	3,866	-	-	3,866	Net. Pat. Rev.	7,554,988	2,224,512	387	3,479
Insurance	26	-	123,197	-	-	123,197	Net. Pat. Rev.	7,554,988	2,224,512	95,174	28,023
Other	27	-	-	-	-	-	N/A			-	-
Depreciation	30	-	499,491	-	-	499,491	SQFT	20,301	19,792	252,916	246,575
Amortization	31	-	-	-	-	-	Net. Pat. Rev.	7,554,988	2,224,512	-	-
Interest	32	-	290,918	-	-	290,918	SQFT	20,301	19,792	147,306	143,612
Real Estate Taxes	33	-	80,236	-	-	80,236	SQFT	20,301	19,792	40,627	39,609
Rent - Facilities and Grounds	34	-	4,120	-	-	4,120	SQFT	20,301	19,792	2,086	2,034
Rent - Equipment and Vehicles	35	-	24,770	-	-	24,770	Net. Pat. Rev.	7,554,988	2,224,512	19,136	5,634
Other	36	-	-	-	-	-	N/A			-	-
Medically Necessary Transportation	38	-	-	-	-	-	N/A			-	-
Ancillary Service Centers	39	-	612,271	-	-	612,271	Direct	1	-	612,271	-
Barber and Beauty Shop	40	-	18,714	-	-	18,714	Direct	-	1	-	18,714
Coffee and Gift Shops	41	-	-	-	-	-	Direct			-	-
Provider Participation Fee	42	-	406,310	-	-	406,310	Direct	1	-	406,310	-
Other	43	61,776	-	-	-	-	Direct	-	1	-	-
		4,528,881	9,602,342	352,734	157,061	9,092,547				7,347,500	2,254,842

Summary A

08/31/25

[illegible]

Summary B

08/31/25

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

[illegible]

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
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☒

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Ownership Listing-1

ID# 0005785

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

Operator/Licensee

Building Co.

Co. /Home Office

[illegible]

VII. RELATED PARTIES (continued)

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

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

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

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

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

Ending: 08/31/25**Fax Number**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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	USDA		X	Facility Expansion Project	\$32,570.00		\$	7,420,000	\$	7,203,663	05/18/55	3.50%	\$	254,557	1				
2	Triumph Bank		X	Facility Expansion Project	\$8,793.96			4,680,000		4,500,161	09/21/55	7.18%		69,165	2				
3	Triumph Bank		X	Loan Fees										1,224	3				
4															4				
5															5				
	Working Capital																		
6															6				
7															7				
8															8				
9	TOTAL Facility Related				\$41,363.96		\$	12,100,000	\$	11,703,824			\$	324,946	9				
	B. Non-Facility Related*																		
10	Other													347	10				
11	Non-Allowable													(347)	11				
12	Alloc. - Assisted Living													(143,612)	12				
13	Interest Income													(34,028)	13				
14	TOTAL Non-Facility Related						\$		\$				\$	(177,640)	14				
15	TOTALS (line 9+line14)						\$	12,100,000	\$	11,703,824			\$	147,306	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2024 report.				\$	29,036	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.)				\$	41,297	2
3. Under or (over) accrual (line 2 minus line 1).				\$	12,261	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	28,366	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.				\$	40,627	7
Assessed Value from Real Estate Tax Bill: 2024 3,000,360 8						
Real Estate Tax Bill for Calendar Year: 2020 83,997 9						
2021 77,143 10						
2022 84,479 11						
2023 84,479 12						
2024 81,567 13						
2025 Tax Accrual = (\$81,567 * 1.03)/12 * 8 = \$56,009 * 50.63% = \$28,366				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
Nursing Home Allocation = 50.63% (Based on Square Footage)				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resthave Home Whiteside Cnty COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	09 - 17 - 352 - 015	Facility	\$ 24,839.52	\$ 12,576.25
2.	09 - 17 - 352 - 016	Facility	\$ 56,727.34	\$ 28,721.05
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 81,566.86	\$ 41,297.30

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? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

71,809

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1
- C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D.

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living - 37 Units

- F.

List the bed capacity for the building if it differs from the licensed total.

N/A
- G.

Have you properly capitalized all major repairs and equipment purchases?

Yes
- H.

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- I.

Are you presently operating under a sublease agreement?

No
- J.

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.

- K.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Facility			\$ 11,477	1
2	Non-Care Allocation			(5,666)	2
3	TOTALS			\$ 5,811	3

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

09/01/24

Ending:

08/31/25

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1961	1961	\$ 140,758	\$		\$	\$	\$	4
5			1969	1969	326,818						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	6,242						9
10	Various			1976	2,320						10
11	Various			1980	1,681						11
12	Various			1981	1,039						12
13	Various			1982	127,530						13
14	Various			1983	14,116						14
15	Various			1984	22,779						15
16	Various			1985	3,880						16
17	Various			1986	2,698						17
18	Various			1987	2,623						18
19	Various			1988	14,500						19
20	Various			1989	14,220						20
21	Various			1993	208,977						21
22	Various			1996	9,670						22
23	Various			1997	9,260						23
24	Various			1998	2,751						24
25	Various			1999	27,294						25
26	Various			2001	67,722						26
27	Various			2002	335						27
28	Various			2003	49,191						28
29	Various			2004	44,691						29
30	Various			2010	19,280						30
31	Various			2011	2,346						31
32	Various			2014	7,436						32
33	Various			2015	13,700,848						33
34	Various			2016	18,047						34
35	Various			2017	19,146						35
36											36

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

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

See Page 12A, Line 70 for total

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	
37	Various	2020	\$ 2,600	\$		\$	\$	\$	37
38	Various	2021	111,017						38
39	Generator Breaker Replacement	2022	5,800						39
40	Roofing	2022	104,849						40
41	Air Handler & Generator	2022	3,036						41
42	Door Egress Panic Devices	2022	8,247						42
43	HVAC Compressors, VRF Solenoid Valves & Pumps	2022	29,956						43
44	VRF Compressors	2023	28,462						44
45	Fire Wall Modifications - IDPH Compliance	2023	43,406						45
46	Roofing	2023	140,858						46
47	Gazebo	2023	15,095						47
48	Heat Compressor	2023	19,442						48
49	PCB and Room Controllers	2023	2,591						49
50	Nurse Call System	2023	13,232						50
51	HVAC and Pump Repair	2023	16,764						51
52	Concrete Sidewalk	2024	3,017						52
53	HVAC and Pump Repair	2024	57,345						53
54	Generator Repair	2024	9,871						54
55	Renovations - Flooring, Drywall, Paint, Etc.	2024	6,853						55
56	HVAC Repairs, PTAC Units & Exhaust Fans	2025	49,956						56
57	Breaker Repairs	2025	17,320						57
58	Carport and Stone Column Repair	2025	29,705						58
59	Fire Alarm System Repairs	2025	15,470						59
60	Wanderguard Touchpad Exit Controllers	2025	3,389						60
61									61
62	Allocation - Non Care Assets								62
63	Prior Capital Report Assets		(7,396,522)						63
64	2022 (Allocation Method Square Footage)	2022	(74,987)						64
65	2023 (Allocation Method Square Footage)	2023	(138,162)						65
66	2024 (Allocation Method Square Footage)	2024	(38,057)						66
67	2025 (Allocation Method Square Footage)	2025	(57,190)						67
68									68
69	Depreciation			252,916		252,916		3,106,852	69
70	TOTAL (lines 4 thru 69)		\$ 7,901,561	\$ 252,916		\$ 252,916	\$	\$ 3,106,852	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	\$1,142,207	\$	\$	\$		\$	71
72	Current Year Purchases	64,673						72
73	Fully Depreciated Assets							73
74	Non-Care Alloc.	(595,837)						74
75	TOTALS	\$611,043	\$	\$	\$		\$	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	Resident Transportation	2012 Ford Van S2E	2012	\$48,130	\$	\$	\$		\$	76
77	Maintenance	2001 Dodge Ram 1500	2014	10,379						77
78	Maintenance	Truck / Bus	2024	97,853						78
79	Non-Care Alloc.			(77,196)						79
80	TOTALS			\$79,166	\$	\$	\$		\$	80

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)	\$8,597,581	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$252,916	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$252,916	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)	\$3,106,852	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	Land	\$5,666	\$	\$	86
87	Building & Improvements	7,704,918			87
88	Equipment	595,837			88
89	Transportation	77,196			89
90	Depreciation		246,575	3,029,533	90
91	TOTALS	\$8,383,617	\$246,575	\$3,029,533	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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:N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		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	See Supp.				2,086			6
7	TOTAL				\$ 2,086			7

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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?
16. Rental Amount for movable equipment: \$ 19,136 Description: See Supplemental 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

- * 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.

Resthave Home of Whiteside County, Inc.
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Description		Amount		Total
Building Rental				
Storage Rental		4,120		4,120
				-
Non-Allowable: Asst Living		(2,034)		(2,034)
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		2,086		2,086
Equipment Rental				
Aquarium & Bird Aviary		6,884		6,884
Office Equipment & Copiers		17,886		17,886
				-
Non-Allowable: Asst Living		(5,634)		(5,634)
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		19,136		19,136

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(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	39 - 03	hrs	\$		\$ 173,077	\$		\$ 173,077	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,692			32,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			293,301			293,301	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				86,062		86,062	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					423		423	12
13	Other (specify): See Supplemental	39 - 03				26,716			26,716	13
14	TOTAL			\$		\$ 525,786	\$ 86,485		\$ 612,271	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.

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[illegible]

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 2,123,953	\$	1
2	Cash-Patient Deposits	2,659		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	743,556		3
4	Supply Inventory (priced at FIFO - Cost)	8,062		4
5	Short-Term Investments			5
6	Prepaid Insurance	44,323		6
7	Other Prepaid Expenses	10,439		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	426,574		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,359,566	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,477		13
14	Buildings, at Historical Cost	15,258,911		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,710,809		16
17	Accumulated Depreciation (book methods)	(6,136,385)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,844,812	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,204,378	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 501,016	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,659		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	317,874		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,009		32
33	Accrued Interest Payable	303,181		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,180,739	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	11,667,026		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,667,026	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,847,765	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,356,613	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,204,378	\$	48

*(See instructions.)

Resthave Home of Whiteside County, Inc.
Medicaid Cost Report
09/01/24 - 08/31/25

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Maintenance Reserve		370,877				370,877
Real Estate Escrow		1,940				1,940
Employee Loans		3,673				3,673
Refunds Other		50,084				50,084
						-
Sub-Total		426,574		-		426,574
Line 23 - Long Term Assets						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 36 - Other Current Liability						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,390,925	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,390,925	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(34,312)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (34,312)	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)	\$ 1,356,613	24

*

* This must agree with page 17, line 47.

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

09/01/24

Ending:

08/31/25

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	\$ 7,244,369	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,244,369	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,619	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 310,619	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	19,568	13
14	Non-Patient Meals	538	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,106	23
	D. Non-Operating Revenue		
24	Contributions	32,453	24
25	Interest and Other Investment Income***	34,028	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66,481	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	2,224,579	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,224,579	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,866,154	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,785,067	31
32	Health Care	4,105,251	32
33	General Administration	1,913,041	33
	B. Capital Expense		
34	Ownership	933,910	34
	C. Ancillary Expense		
35	Special Cost Centers	756,887	35
36	Provider Participation Fee	406,310	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,900,466	40
41	Income before Income Taxes (line 30 minus line 40)**	(34,312)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (34,312)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,074,397	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,146,998	48
49	Medicare Part A	1,382,025	49
50	Other-(specify) <u>Medicaid Hospice</u>	5,326	50
51	Other-(specify) <u>Insurance</u>	172,110	51
52	Other-(specify) <u>Veterans</u>	463,513	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,244,369	56

Resthabe Home of Whiteside County, Inc.
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[illegible]

Facility Name & ID Number Resthave Home Whiteside Cnty# 0005785

Report Period Beginning:

09/01/24

Ending:

08/31/25

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	1,918	2,080	\$ 101,629	\$ 48.86	1
2	Assistant Director of Nursing	1,078	1,110	49,943	44.99	2
3	Registered Nurses	9,333	9,705	389,744	40.16	3
4	Licensed Practical Nurses	8,754	9,151	325,719	35.59	4
5	CNAs & Orderlies	75,389	78,168	1,830,378	23.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,985	2,119	44,697	21.09	9
10	Activity Assistants	6,464	6,560	100,930	15.39	10
11	Social Service Workers	3,954	4,220	108,024	25.60	11
12	Dietician					12
13	Food Service Supervisor	1,850	2,080	46,926	22.56	13
14	Head Cook	5,862	6,251	109,988	17.60	14
15	Cook Helpers/Assistants	18,197	18,617	315,046	16.92	15
16	Dishwashers					16
17	Maintenance Workers	6,804	7,135	139,221	19.51	17
18	Housekeepers	19,896	20,849	344,193	16.51	18
19	Laundry					19
20	Administrator	1,956	2,080	106,823	51.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,067	2,220	54,834	24.70	23
24	Clerical	7,129	7,405	166,709	22.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl.</u>	7,654	8,320	294,077	35.35	33
34	TOTAL (lines 1 - 33)	180,290	188,070	\$ 4,528,881 *	\$ 24.08	34

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		\$ 6,407	01 - 03	35
36	Medical Director		18,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,035	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		181	11 - 03	44
45	Social Service Consultant		2,088	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,711		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 468,186	10 - 03	50
51	Licensed Practical Nurses		100,790	10 - 03	51
52	Certified Nurse Assistants/Aides		193,359	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 762,335		53

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

** See instructions.

Resthabe Home of Whiteside County, Inc.
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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
MDS Coordinator	10	1,842	2,080	76,340	36.70		
AL - Clinical Nurse	10	2,022	2,080	94,089	45.24		
AL - Director	21	1,902	2,080	61,872	29.75		
Marketing Director	43	1,888	2,080	61,776	29.70		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		7,654	8,320	294,077	35.35		

Contracted Services

Contracted Services					
Total				-	-

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Jill Smith	Administrator	0	\$ 106,823	Workers' Compensation Insurance		\$ 107,515	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		15,419	Advertising: Employee Recruitment	5,848	
				FICA Taxes		339,468	Health Care Worker Background Check	1,110	
				Employee Health Insurance		187,398	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	1,424	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	7,564	
				Retirement Plan		8,658	Dues and Suscriptions	2,520	
				Life Insurance		1,208	Licenses	6,642	
				Other		67,827			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Non-Allowable: Assisted Living	(5,820)	
B. Administrative - Other							Less: Public Relations Expense	()	
Description			Amount				PAC and Lobbying payments	(1,513)	
JHG, LLC - Management Services			\$ 240,000				All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 240,000						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Sikich, LLP	Accounting	\$	28,950			\$	Out-of-State Travel	\$	
Jeremy Brune & Assoc., LLC	Accounting		67,217						
Duane Morris	Legal		2,457						
Fully Managed	IT Consulting		51,051				In-State Travel		
Paychex	Data Processing		31,712						
Pointclickcare Technologies	Data Processing		49,905						
Inovalon	Data Processing		19,904						
SchedulePop	Data Processing		2,572				Seminar Expense	8,198	
American Healthtech	Data Processing		1,945				Non-Allowable: Assisted Living	(3,215)	
Other Online Applications	Data Processing		5,217						
JHG, LLC	Business Office Support		10,416						
Other	Non-Allowable		900						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	Entertainment Expense	()	
			\$ 272,246				(agree to Sch. V, line 24, col. 8)	\$ 4,983	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Resthave Home Whiteside Cnty

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>6,051</u> |
| | |
| | |
| | <u>6,051</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>1,513</u> |
| | |
| | |
| | <u>1,513</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>7,564</u> |
| | |
| | |
| | <u>7,564</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 39,226 Line 10 - 02
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 406,310
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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 - See Pg. 11 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 538
- (12) 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? Ln. 14
- 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? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sikich, LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (15) 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.