



Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,898	5,961	3,560	30,419	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,898	5,961	3,560	30,419	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.03%

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

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

DAY CARE

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 January 1, 2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 119 and days of care provided 3,518

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 1/1 to 12/31/05 Fiscal Year: 1/1 to 12/31/05

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	138,281	13,353	842	152,476		152,476	(853)	151,623		1
2	Food Purchase		129,482		129,482		129,482	(1,742)	127,740		2
3	Housekeeping	63,944	14,946	25,901	104,791		104,791		104,791		3
4	Laundry	24,486	10,842	11,424	46,752		46,752		46,752		4
5	Heat and Other Utilities			97,424	97,424		97,424		97,424		5
6	Maintenance	65,282	35,664	45,930	146,876		146,876	(16,198)	130,678		6
7	Other (specify):* See trial balance			2,891	2,891		2,891		2,891		7
8	<b>TOTAL General Services</b>	291,993	204,287	184,412	680,692		680,692	(18,793)	661,899		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,056,590	92,258	8,238	1,157,086		1,157,086	(1,317)	1,155,769		10
10a	Therapy		347	227,320	227,667		227,667		227,667		10a
11	Activities	31,940	2,434	2,042	36,416		36,416		36,416		11
12	Social Services	17,951	1,443		19,394		19,394		19,394		12
13	CNA Training										13
14	Program Transportation			4,733	4,733		4,733		4,733		14
15	Other (specify):* See trial balance			5,315	5,315		5,315		5,315		15
16	<b>TOTAL Health Care and Programs</b>	1,106,481	96,482	263,248	1,466,211		1,466,211	(1,317)	1,464,894		16
	<b>C. General Administration</b>										
17	Administrative	116,965		214,452	331,417		331,417	(20,936)	310,481		17
18	Directors Fees										18
19	Professional Services			16,863	16,863		16,863		16,863		19
20	Dues, Fees, Subscriptions & Promotions			14,823	14,823		14,823	(3,155)	11,668		20
21	Clerical & General Office Expenses	4,895	22,258	38,127	65,280		65,280	(8,309)	56,971		21
22	Employee Benefits & Payroll Taxes			163,252	163,252		163,252	(7,410)	155,842		22
23	Inservice Training & Education										23
24	Travel and Seminar			34,867	34,867		34,867		34,867		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,956	140,956		140,956		140,956		26
27	Other (specify):* See trial balance			33,754	33,754		33,754	(21,695)	12,059		27
28	<b>TOTAL General Administration</b>	121,860	22,258	657,094	801,212		801,212	(61,505)	739,707		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,520,334	323,027	1,104,754	2,948,115		2,948,115	(81,615)	2,866,500		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			23,858	23,858		23,858	378	24,236			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,016	91,016		91,016	(11,412)	79,604			32
33	Real Estate Taxes			55,840	55,840		55,840		55,840			33
34	Rent-Facility & Grounds			355,482	355,482		355,482		355,482			34
35	Rent-Equipment & Vehicles			6,902	6,902		6,902		6,902			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			533,098	533,098		533,098	(11,034)	522,064			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,155		6,155		6,155		6,155			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* See trial balance			54,255	54,255		54,255		54,255			43
44	<b>TOTAL Special Cost Centers</b>		6,155	119,408	125,563		125,563		125,563			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,520,334	329,182	1,757,260	3,606,776		3,606,776	(92,649)	3,514,127			45

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning: 1/1/05

Ending: 12/31/05

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,742)	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	(11,412)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	1		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	(6,760)	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	(19,966)	27		24
25	Fund Raising, Advertising and Promotional	(3,155)	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	(27,242)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (70,396)		\$	30

OHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,253)	various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (22,253)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (92,649)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

White Hall Nursing & Rehabilitation Center

ID# 0046896

Report Period Beginning: 1/1/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Remove Non Allowable Marketing Costs	\$ (1,549)	21	1
2	Remove REIT Inspection Costs	(1,729)	27	2
3	Remove Employee Recognition Program >\$35/EE	(5,867)	22	3
4	Offset Interco Sold Services Revenue	(13,928)	6	4
5	Offset Interco Sold Services Revenue	(1,543)	22	5
6	Remove Interco Purchased Services Mark Up	(734)	1	6
7	Capitalize Repairs & Maintenance for Medicaid	(2,270)	6	7
8	Amortization of LHI Capitalized for Medicaid	378	30	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				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	<b>Total</b>	(27,242)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(853)	0	0	0	0	0	0	0	0	0	0	(853)	1
2	Food Purchase	(1,742)	0	0	0	0	0	0	0	0	0	0	(1,742)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(16,198)	0	0	0	0	0	0	0	0	0	0	(16,198)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(18,793)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(18,793)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(1,317)	0	0	0	0	0	0	0	0	0	(1,317)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(1,317)</b>	<b>0</b>	<b>(1,317)</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(20,936)	0	0	0	0	0	0	0	0	0	(20,936)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,155)	0	0	0	0	0	0	0	0	0	0	(3,155)	20
21	Clerical & General Office Expenses	(8,309)	0	0	0	0	0	0	0	0	0	0	(8,309)	21
22	Employee Benefits & Payroll Taxes	(7,410)	0	0	0	0	0	0	0	0	0	0	(7,410)	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	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(21,695)	0	0	0	0	0	0	0	0	0	0	(21,695)	27
28	<b>TOTAL General Administration</b>	<b>(40,569)</b>	<b>(20,936)</b>	<b>0</b>	<b>(61,505)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(59,362)</b>	<b>(22,253)</b>	<b>0</b>	<b>(81,615)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

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	378	0	0	0	0	0	0	0	0	0	0	378	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,412)	0	0	0	0	0	0	0	0	0	0	(11,412)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>(11,034)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,034)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(70,396)</b>	<b>(22,253)</b>	<b>0</b>	<b>(92,649)</b>	<b>45</b>								

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning: 1/1/05

Ending: 12/31/05

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See attached schedule detailing information for Schedule VII, Section 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Administrative Services Costs	\$ 214,452	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 193,516	\$ (20,936)	1
2	V	34 Sublease Building & Equip	355,482	Tara Midwest, LLC	0.00%	355,482		2
3	V	10 Consulting Pharmacy Services	4,760	Tara Pharmacy SE, LLC	0.00%	3,443	(1,317)	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		\$ 574,694			\$ 552,441	\$ * (22,253)	14

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

## 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	Donald T. Denz	Co-CEO and CFO	See attachment	45.00	***	0.97	2.42	Finance	\$ 4,943	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.97	2.42	Operations	4,943	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.97	2.42	Quality Assuranc	7,197	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.97	2.42	Admissions	4,361	17	5
6											6
7											7
8	*** Compensation paid only through Support Office and allocated share reported in column 7.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,444		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 Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Aurora Cares, LLC d/b/a Tara Cares  
 Street Address 3690 Southwestern Boulevard  
 City / State / Zip Code Orchard Park, NY 14127  
 Phone Number ( 716)662-4955  
 Fax Number ( 716)662-2529

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<u>17</u>	<u>Administrative Services Costs</u>	<u>Days</u>	<u>1,260,156</u>	<u>34</u>	<u>\$ 8,003,827</u>	<u>\$ 30,468</u>	<u>\$ 193,516</u>	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					\$ 8,003,827	\$	\$ 193,516	25

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

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	10
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Health Care REIT, Inc.		X	Acquisition of Operating Rights	Interest only until Maturity	12-31-04	\$ 1,466,300	\$ 1,466,300	6/30/2018	5.7500	\$ 84,235	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	Health Care REIT, Inc.		X	Working Capital	Interest only	12-31-04	109,195	109,195	12/31/2007	Prime+3	6,781	6
7					with balance to amortize down					10.3900		7
8					evenly in 2007 thru 12/31/07				effective rate at 12/31/05			8
9	<b>TOTAL Facility Related</b>						\$ 1,575,495	\$ 1,575,495			\$ 91,016	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,575,495	\$ 1,575,495			\$ 91,016	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.)

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ N/A	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.)		\$ 59,200	2
3. Under or (over) accrual (line 2 minus line 1).		\$ N/A	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 55,840	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 55,840	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	45,419	8
	2001	47,707	9
	2002	48,707	10
	2003	53,181	11
	2004	59,200	12
	<b>FOR OHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME White Hall Nursing & Rehabilitation Center COUNTY Greene

FACILITY IDPH LICENSE NUMBER 0046896

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

TELEPHONE (716) 662-4955, ext 392 FAX #: (716) 662-4468

**A. Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-53-34-400-002</u>	<u>620 W. Bridgeport</u>	\$ <u>59,200.04</u>	\$ <u>59,200.04</u>
2. _____	<u>3W JC 536</u>	\$ _____	\$ _____
3. _____	<u>34-12-12</u>	\$ _____	\$ _____
4. _____	<u>PT N MID PT E1/2 SE</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>59,200.04</u>	\$ <u>59,200.04</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES   X   NO

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896 Report Period Beginning:

1/1/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 18,902 B. General Construction Type: Exterior Brick Frame Metal Number 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).

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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: 269,573 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)  
3. Current Period Amortization: 53,914 4. Dates Incurred: Prior to January 1, 2005

Nature of Costs: Includes capitalized pre-opening salaries, fringe benefits and other costs incurred prior to 1/01/05 and allocated via related organization.  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Alumalite Sign		2005	797	40	10	40		40	9
10		Ductwork		2005	65,173	1,630	20	1,630		1,630	10
11		EPDM Roof System		2005	213,004	10,650	10	10,650		10,650	11
12		Fire Alarm System		2005	30,608	1,530	10	1,530		1,530	12
13		Service Doors (2), Break Room Door (1)		2005	4,650	179	13	179		179	13
14		Drywall seven (7) rooms		2005	1,983	76	13	76		76	14
15		Generator Repairs, capitalized for Medicaid		2005	2,270	378	3	378		378	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>318,485</b>	\$	<b>14,483</b>	\$	<b>14,483</b>	\$	<b>14,483</b>	70

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	110,280	9,484	9,484			9,484	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 110,280	\$ 9,484	\$ 9,484	\$		\$ 9,484	75

D. Vehicle Depreciation (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	1992 Dodge Ram B150 Van	2005	\$ 1,615	\$ 269	\$ 269	\$	3	\$ 269	76
77										77
78										78
79										79
80	TOTALS			\$ 1,615	\$ 269	\$ 269	\$		\$ 269	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 430,380	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,236	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)	\$ 24,236	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Unitime Payroll System	\$ 15,206	92
93			93
94			94
95		\$ 15,206	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.

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Health Care REIT, Inc.

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:	<u>1972</u>	<u>119</u>	<u>1/1/05</u>	\$ <u>355,482</u>	<u>13.5 yrs.</u>	<u>1-15 yr.</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>119</b>		\$ <b>355,482</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 12/31/2004  
Ending 6/30/2018

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2006</u>	\$ <u>355,476</u>
13.	<u>12/31/2007</u>	\$ <u>355,476</u>
14.	<u>12/31/2008</u>	\$ <u>355,476</u>

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: 60 day notice \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 8,089 Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

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

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

**B. EXPENSES**

ALLOCATION OF COSTS (d)

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

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	1,950	\$ 94,834	\$	1,950	\$ 94,834	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		192	11,927		192	11,927	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,908	120,559		2,908	120,559	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	5,050	\$ 227,320	\$	5,050	\$ 227,320	14

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (204,616)	\$	1
2	Cash-Patient Deposits	4,035		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 19,966 )	534,547		3
4	Supply Inventory (priced at Cost )	3,344		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,467		6
7	Other Prepaid Expenses	18,947		7
8	Accounts Receivable (owners or related parties)	15,796		8
9	Other(specify): <u>Deposits&amp;Non Resident A/R (see TB)</u>	15,648		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 389,168	\$	10
<b>B. Long-Term Assets</b>				
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	316,215		15
16	Equipment, at Historical Cost	111,895		16
17	Accumulated Depreciation (book methods)	(23,858)		17
18	Deferred Charges	1,075,275		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): <u>Construction in Progress</u>	15,206		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,494,733	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,883,901	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 103,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,035		28
29	Short-Term Notes Payable	109,195		29
30	Accrued Salaries Payable	148,418		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,333		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,740		32
33	Accrued Interest Payable	955		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Employee Benefits Payable</u>	5,749		36
37	<u>Accrued Expenses</u>	115,574		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 589,116	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,466,300		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,466,300	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,055,416	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (171,515)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,883,901	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(171,515)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (171,515)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (171,515)	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/05 Ending: 12/31/05

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,907,519	1
2	Discounts and Allowances for all Levels	370,593	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,278,112	3
<b>B. Ancillary Revenue</b>			
4	Day Care	180	4
5	Other Care for Outpatients		5
6	Therapy	122,872	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 123,052	8
<b>C. Other Operating Revenue</b>			
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	1,742	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,449	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,191	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,412	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,412	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Sold Services Revenue</b>	19,494	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 19,494	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,435,261	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	680,692	31
32	Health Care	1,466,211	32
33	General Administration	801,212	33
<b>B. Capital Expense</b>			
34	Ownership	533,098	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	60,410	35
36	Provider Participation Fee	65,153	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,606,776	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(171,515)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (171,515)	43

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

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

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

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning:

1/1/05

Ending:

12/31/05

**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	1,600	1,821	\$ 43,514	\$ 23.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,428	5,750	102,484	17.82	3
4	Licensed Practical Nurses	22,691	24,345	390,899	16.06	4
5	CNAs & Orderlies	52,481	55,241	486,055	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,207	2,311	20,438	8.84	9
10	Activity Assistants	1,263	1,282	11,502	8.97	10
11	Social Service Workers	1,730	1,977	17,951	9.08	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,071	39,183	18.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,190	7,792	57,955	7.44	15
16	Dishwashers	5,791	5,962	41,143	6.90	16
17	Maintenance Workers	5,373	5,435	65,282	12.01	17
18	Housekeepers	7,147	7,171	63,944	8.92	18
19	Laundry	3,366	3,441	24,486	7.12	19
20	Administrator	2,048	2,064	62,454	30.26	20
21	Assistant Administrator					21
22	Other Administrative	2,035	2,163	24,800	11.47	22
23	Office Manager	2,038	2,118	29,712	14.03	23
24	Clerical	501	584	4,895	8.38	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	300	300	2,102	7.01	31
32	Other Health Ca MDS Coordinator	371	419	10,032	23.94	32
33	Other(specify) Nrsng Admin Clerical	2,477	2,608	21,503	8.25	33
34	TOTAL (lines 1 - 33)	128,037	134,855	\$ 1,520,334 *	\$ 11.27	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	5	\$ 252	1-3	35
36	Medical Director	contract	15,600	9-3	36
37	Medical Records Consultant	3.50/bed	720	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	3.50 & 10/bed	7,028	10-3	39
40	Physical Therapy Consultant	0	0	10a-3	40
41	Occupational Therapy Consultant	0	0	10a-3	41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant	0	0	10a-3	43
44	Activity Consultant	25.25 hrs	1,443	11-3	44
45	Social Service Consultant	25.25 hrs	1,443	12-3	45
46	Other(specify)				46
47	Medical Records Consultant	15	490		47
48					48
49	TOTAL (lines 35 - 48)	20	\$ 26,976		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$	10-3	50
51	Licensed Practical Nurses	0		10-3	51
52	Certified Nurse Assistants/Aides	0		10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning: 1/1/05

Ending: 12/31/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Theresa Chapman	Administrator	0	\$ 10,384	Workers' Compensation Insurance	\$ 9,795	IDPH License Fee	\$ 6,308	
Kelly Kelley	Administrator	0	52,070	Unemployment Compensation Insurance	27,066	Advertising: Employee Recruitment	6,308	
				FICA Taxes	109,987	Health Care Worker Background Check	1,160	
Other Administrative Salaries		0	54,511	Employee Health Insurance	5,682	(Indicate # of checks performed)		
				Employee Meals		Facility Advertising	646	
				Illinois Municipal Retirement Fund (IMRF)*		Professional License	164	
				Employee Benefits - Other	3,312	IL Health Care Association	6,545	
						Non Allowable-IL Health Care Assn	(2,509)	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 116,965					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	( )	
Tara Cares Administrative Services Fee			\$ 214,452			Non-allowable advertising	(646)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 214,452	TOTAL (agree to Schedule V, line 22, col.8)	\$ 155,842	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,668	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Ernst & Young	Accounting & Tax		\$ 9,833					
							In-State Travel	32,009
Various Legal --- see attached detailed listing			7,030					
							Seminar Expense	2,858
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		TOTAL	\$ 34,867
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 16,863					

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

# 0046896

Report Period Beginning: 1/1/05

Ending: 12/31/05

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number White Hall Nursing &amp; Rehabilitation Center

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$4,063 net of non-allowable
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,260 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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,153  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,742
- (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? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. 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) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**ILLINOIS MEDICAID COST REPORT  
EDIT CHECKS**

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16-May-06

								<b>Proof</b>	
Schedule V	Page 4	Line 45-4	3,606,776	Must Equal	Schedule XVII	Page 19	Line 40	3,606,776	0 TOTAL Expense Unadjusted
Schedule V	Page 4	Line 45-1	1,520,334	Must Equal	Schedule XVIII	Page 20	Line 34-3	1,520,334	0 Total Salary Expense
Schedule V	Page 4	Line 45-7	(92,649)	Must Equal	Schedule VI	Page 5	Line 37-1	(92,649)	0 Total Adjustments
Schedule XI	Page 12a	Line 70-4	318,485	Must Equal	Schedule XV	Page 17	Line 15-1	316,215	2,270 Total Bldg Impr - Fx Asset <b>ok-AJE 13</b>
Schedule XI	Page 13	Line 75-1	110,280	} Must Equal	Schedule XV	Page 17	Line 16-1	111,895	0 Total Equip +Vehicles
	plus	Line 80-4	1,615						
Schedule XI	Page 13	Line 81-2	430,380	Must Equal	Schedule XV	Page 17	Ln 15-1+ plus Line 16-1	428,110	2,270 Summary - Total Fx Assets <b>ok-AJE 13</b>
Schedule XI	Pg 12a	Line 70-5	14,483	} Must Equal	Schedule XV	Page 17	Line 17-1	(23,858)	378 Total Accum Depr <b>ok-AJE 14</b>
plus	Pg 13	Line 75-2	9,484						
plus	Pg 13	Line 80-5	269						
Schedule XI	Page 13	Line 82-2	24,236	Must Equal	Schedule XV	Page 17	Line 17-1	(23,858)	378 Summary - Total Accum Dep <b>ok-AJE 14</b>
Schedule XI	Page 13	Line 95	15,206	Must Equal	Schedule XV	Page 17	Line 23-1	15,206	0 Cons in Progress
Schedule XII	Page 14	Line 7-4	355,482	Must Equal	Schedule V	Page 4	Line 34-4	355,482	0 Rent Expense-Facility
Schedule XIV	Page 16	Line 14-5	227,320	Must Equal	Schedule V	Page 3	Line 10a-3	227,320	0 PT/OT/ST
and	Page 16	Line 14-8	227,320	Must Equal	Schedule V	Page 3	Line 10a-3	227,320	0 PT/OT/ST
Schedule XV	Page 17	Line 25-1	1,883,901	Must Equal	Schedule XV	Page 17	Line 48-1	1,883,901	0 Assets = Liabilities
Schedule XVI	Page 18	Line 24	(171,515)	Must Equal	Schedule XV	Page 17	Line 47-1	(171,515)	0 BS Equity = Equity Detail
Schedule XIX	Page 21	Total A	116,965	Must Equal	Schedule V	Page 3	Line 17 -1	116,965	0 Admin Salaries
Schedule XIX	Page 21	Total B	214,452	Must Equal	Schedule V	Page 3	Line 17 -2	214,452	0 Tara Cares Fee
Schedule XIX	Page 21	Total C	16,863	Must Equal	Schedule V	Page 3	Line 19 -3	16,863	0 Professional Fees
Schedule XIX	Page 21	Total D	155,842	Must Equal	Schedule V	Page 3	Line 22-8	155,842	0 EE Benefits
Schedule XIX	Page 21	Total F	11,668	Must Equal	Schedule V	Page 3	Line 20-8	11,668	0 Dues,Fees, Subs
Schedule XIX	Page 21	Total G	34,867	Must Equal	Schedule V	Page 3	Line 24-8	34,867	0 Travel & Seminars

Schedule XVII, Expenses line 31 through 36 have been entered as "linked" to Sch V; therefore, not included in edit checks above