

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	20,493	7,380	5,063	32,936	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,493	7,380	5,063	32,936	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.83%

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 01/01/05

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 4,769

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 1/1 to 12/31/07 Fiscal Year: 1/1 to 12/31/07

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	145,310	13,515	11,413	170,238		170,238	(998)	169,240		1
2	Food Purchase		150,170		150,170		150,170	(3,217)	146,953		2
3	Housekeeping	117,382	17,944	1,019	136,345		136,345	(846)	135,499		3
4	Laundry	18,240	9,119		27,359		27,359		27,359		4
5	Heat and Other Utilities			98,982	98,982		98,982		98,982		5
6	Maintenance	26,148	15,025	27,294	68,467		68,467	(4,287)	64,180		6
7	Other (specify):* see trial balance			3,147	3,147		3,147		3,147		7
8	TOTAL General Services	307,080	205,773	141,855	654,708		654,708	(9,348)	645,360		8
	B. Health Care and Programs										
9	Medical Director			14,713	14,713		14,713		14,713		9
10	Nursing and Medical Records	1,179,613	103,839	16,346	1,299,798		1,299,798	2,458	1,302,256		10
10a	Therapy		1,721	361,897	363,618		363,618	35,458	399,076		10a
11	Activities	32,805	2,846	2,200	37,851		37,851	(935)	36,916		11
12	Social Services	20,689		1,655	22,344		22,344		22,344		12
13	CNA Training										13
14	Program Transportation			6,499	6,499		6,499		6,499		14
15	Other (specify):* see trial balance			5,502	5,502		5,502	(1,381)	4,121		15
16	TOTAL Health Care and Programs	1,233,107	108,406	408,812	1,750,325		1,750,325	35,600	1,785,925		16
	C. General Administration										
17	Administrative	148,438		227,016	375,454		375,454	(1,537)	373,917		17
18	Directors Fees										18
19	Professional Services			15,555	15,555		15,555	(3,627)	11,928		19
20	Dues, Fees, Subscriptions & Promotions			16,904	16,904		16,904	(5,090)	11,814		20
21	Clerical & General Office Expenses	1,670	31,268	36,452	69,390		69,390	(10,050)	59,340		21
22	Employee Benefits & Payroll Taxes			471,302	471,302		471,302	(7,162)	464,140		22
23	Inservice Training & Education										23
24	Travel and Seminar			37,068	37,068		37,068	(253)	36,815		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,178	62,178		62,178	(2,600)	59,578		26
27	Other (specify):* see trial balance			88,946	88,946		88,946	(65,947)	22,999		27
28	TOTAL General Administration	150,108	31,268	955,421	1,136,797		1,136,797	(96,266)	1,040,531		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,690,295	345,447	1,506,088	3,541,830		3,541,830	(70,014)	3,471,816		29

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

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			33,851	33,851	33,851	2,515	36,366			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			133,902	133,902	133,902	(3,776)	130,126			32
33	Real Estate Taxes			69,741	69,741	69,741		69,741			33
34	Rent-Facility & Grounds			460,054	460,054	460,054	(1,230)	458,824			34
35	Rent-Equipment & Vehicles			33,040	33,040	33,040		33,040			35
36	Other (specify):* Amtz Customer Rights			4,507	4,507	4,507		4,507			36
37	TOTAL Ownership			735,095	735,095	735,095	(2,491)	732,604			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,319	1,319	1,319		1,319			39
40	Barber and Beauty Shops		575	256	831	831		831			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			123,662	123,662	123,662	(18,058)	105,604			43
44	TOTAL Special Cost Centers		575	190,390	190,965	190,965	(18,058)	172,907			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,690,295	346,022	2,431,573	4,467,890	4,467,890	(90,563)	4,377,327			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: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (215)	2	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,847)	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	(3,776)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,125)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(155)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,510)	21		18
19	Entertainment				19
20	Contributions	(950)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,928)	27		24
25	Fund Raising, Advertising and Promotional	(5,090)	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	(46,567)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,163)		\$	30

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)		various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (130,163)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

White Hall Nursing & Rehabilitation Center

ID# 0046896

Report Period Beginning: 1/1/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Remove Non Allowable Admissions Costs	\$ (4,265)	21	1
2	Remove Non Allowable Admin-Contracted Costs	0	27	2
3	Remove Employee Recognition Program >\$25/EE	(4,521)	22	3
4	Offset Interco Sold Services Revenue	(1,725)	22	4
5	Offset Interco Sold Services Revenue	(127)	6	5
6	Offset Interco Sold Services Revenue	(1,542)	17	6
7	Offset Interco Sold Services Revenue	(481)	10	7
8	Offset Interco Sold Services Revenue	(148)	10	8
9	Remove Interco Purchased Services Mark Up	(998)	1	9
10	Capitalize Repairs & Maintenance for Medicaid	(4,160)	6	10
11	Amortization of LHI Capitalized for Medicaid	2,515	30	11
12	Offset Day Care Revenue	(40)	11	12
13	Offset Day Care Revenue	(1,230)	34	13
14	Offset Restricted Work.Comp.Interest Income	(905)	22	14
15	Remove Non Allowable Visa Costs	(253)	24	15
16	Remove Non Allowable Insurance Costs	(2,600)	26	16
17	Remove Non Allowable IV Prescription Drug Costs	(3,959)	43	17
18	Remove Non Allowable Prior Year Costs	(14,086)	43	18
19	Remove Non Allowable Nrsg Admin-Purch Svcs	(1,381)	15	19
20	Remove Non Allowable Nrsg Other Fees	(69)	27	20
21	Remove Non Allowable Admin Other	(150)	21	21
22	Offset Interco Sold Services Revenue	(1,074)	10	22
23	Offset Interco Sold Services Revenue	(576)	3	23
24	Offset Interco Sold Services Revenue	(270)	3	24
25	Offset Interco Sold Services Revenue	(895)	11	25
26	Remove Non Allowable Acctg Tax Fees E&Y	(3,627)	19	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(46,567)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nursing & Rehabilitation Center# 0046896 Report Period Beginning:

1/1/07

Ending: 12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(998)	0	0	0	0	0	0	0	0	0	0	(998)	1
2	Food Purchase	(3,217)	0	0	0	0	0	0	0	0	0	0	(3,217)	2
3	Housekeeping	(846)	0	0	0	0	0	0	0	0	0	0	(846)	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	(4,287)	0	0	0	0	0	0	0	0	0	0	(4,287)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,348)	0	0	0	0	0	0	0	0	0	0	(9,348)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,703)	4,161	0	0	0	0	0	0	0	0	0	2,458	10
10a	Therapy	0	35,458	0	0	0	0	0	0	0	0	0	35,458	10a
11	Activities	(935)	0	0	0	0	0	0	0	0	0	0	(935)	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):*	(1,381)	0	0	0	0	0	0	0	0	0	0	(1,381)	15
16	TOTAL Health Care and Programs	(4,019)	39,619	0	35,600	16								
	C. General Administration													
17	Administrative	(1,542)	5	0	0	0	0	0	0	0	0	0	(1,537)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,627)	0	0	0	0	0	0	0	0	0	0	(3,627)	19
20	Fees, Subscriptions & Promotions	(5,090)	0	0	0	0	0	0	0	0	0	0	(5,090)	20
21	Clerical & General Office Expenses	(10,050)	0	0	0	0	0	0	0	0	0	0	(10,050)	21
22	Employee Benefits & Payroll Taxes	(7,151)	(11)	0	0	0	0	0	0	0	0	0	(7,162)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(253)	0	0	0	0	0	0	0	0	0	0	(253)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(65,947)	0	0	0	0	0	0	0	0	0	0	(65,947)	27
28	TOTAL General Administration	(96,260)	(6)	0	(96,266)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,627)	39,613	0	(70,014)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	2,515	0	0	0	0	0	0	0	0	0	0	2,515	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,776)	0	0	0	0	0	0	0	0	0	0	(3,776)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,230)	0	0	0	0	0	0	0	0	0	0	(1,230)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,491)	0	0	0	0	0	0	0	0	0	0	(2,491)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(18,045)	(13)	0	0	0	0	0	0	0	0	0	(18,058)	43
44	TOTAL Special Cost Centers	(18,045)	(13)	0	(18,058)	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,163)	39,600	0	(90,563)	45								

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

0046896

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	\$ 227,016	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 227,021	\$ 5	1
2	V	34 Sublease Building & Equip	460,054	Tara Midwest, LLC	0.00%	460,054		2
3	V	10 Pharmacy Consulting Services	14,280	Tara Pharmacy SE, LLC	0.00%	18,441	4,161	3
4	V	43 Flu Vaccines for Residents	1,083	Tara Pharmacy SE, LLC	0.00%	1,070	(13)	4
5	V	22 Flu Vaccines for Employees	923	Tara Pharmacy SE, LLC	0.00%	912	(11)	5
6	V	10a Physical Therapy Fees	174,099	Tara Therapy, LLC	0.00%	206,467	32,368	6
7	V	10a Occupational Therapy Fees	140,765	Tara Therapy, LLC	0.00%	139,613	(1,152)	7
8	V	10a Speech Therapy Fees	47,033	Tara Therapy, LLC	0.00%	51,275	4,242	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,065,253			\$ 1,104,853	\$ * 39,600	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: 1/1/07 Ending: 12/31/07

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	***	0.92	2.31	Fin/Opr	\$ 5,177	17	1
2	Norbert A. Bennett	Co-CEO	See attachment	45.00	***	0.92	2.31	Fin/Opr	5,177	17	2
3	Gail M. Polanski	SVP Quality	See attachment	10.00	***	0.92	2.31	Qual. Assur.	6,249	17	3
4		Assurance									4
5	Suzette Wilson	Vice President	See attachment	0.00	***	0.92	2.31	VP	4,107	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	\$ 20,710		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: 1/1/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administrative Services Costs	Days		\$	\$		\$	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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Health Care REIT, Inc.		X	Acquisition of Operating Rights	Interest only	12/31/04	\$ 1,466,300	\$ 1,466,300	6/30/2018	5.7500	\$ 84,276	1						
2					until Maturity							2						
3	Health Care REIT, Inc.		X	Capital Improvements	Prin.&Interest	1/23/06	628,950	369,216	1/23/2010	9.3800	42,823	3						
4					with add'l 25 basis points each year							4						
5												5						
Working Capital																		
6	Health Care REIT, Inc.		X	Working Capital	Interest only	12/31/04	109,195		12/31/2007	Prime+3	6,803	6						
7					with balance to amortize down					10.6500		7						
8					evenly in 2007 thru 12/31/07				effective rate at 12/31/07			8						
9	TOTAL Facility Related						\$ 2,204,445	\$ 1,835,516			\$ 133,902	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,204,445	\$ 1,835,516			\$ 133,902	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: 1/1/07

Ending: 12/31/07

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

B. Real Estate Taxes

<p>Important, 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 2006 report.		\$ <u>65,400</u>	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.)		\$ <u>66,416</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>1,016</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>68,725</u>	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.		\$ <u>69,741</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002 <u>48,707</u>	8	
	2003 <u>53,181</u>	9	
	2004 <u>59,200</u>	10	
	2005 <u>62,286</u>	11	
	2006 <u>66,416</u>	12	
	FOR BHF USE ONLY		
	13 FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>\$ 66,416.30</u>	<u>\$ 66,416.30</u>
2. _____	<u>3W JC 536</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	<u>34-12-12</u>	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	<u>PT N MID PT E1/2 SE</u>	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
	TOTALS	<u>\$ 66,416.30</u>	<u>\$ 66,416.30</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

0046896 Report Period Beginning:

1/1/07 Ending:

12/31/07

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).

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: 849,335 2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8 4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc. capitalized pre-opening salaries, fringe benefits & other costs incurred prior 1/1/05. Costs allocated via related org cost & reported on Sch V.
(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:

1/1/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Alumalite Sign		2005	797	80	10	80		199	9
10		Generator Repairs, capitalized for Medicaid		2005	2,270	757	3	757		1,892	10
11		Auto Cad Design for Fire Alarm System		2006	1,080	108	10	108		162	11
12		Sign Pillars w/ Lighting		2006	8,975	898	10	898		1,346	12
13		Telewiring - Computer Outlets (2)		2006	1,473	37	40	37		56	13
14		Window Treatment		2006	13,663	1,366	10	1,366		2,049	14
15		Shower Room Renovations		2006	46,015	3,835	12	3,835		5,752	15
16		Measure & Install Blinds in Facility		2006	10,998	2,200	5	2,200		3,299	16
17		Handrail and Background Staining		2006	14,880	1,240	12	1,240		1,860	17
18		Electrical Wiring (lighting & smoke detectors)		2006	23,000	1,917	12	1,917		2,875	18
19		Concrete Sidewalk		2006	900	75	12	75		113	19
20		Sprinkler System Repairs, capitalized for Medicaid		2006	3,194	1,065	3	1,065		1,597	20
21		Installation of Data Outlet Recepticles for Medicaid		2007	4,160	693	3	693		693	21
22		Dry Wall - Entire Building		2007	10,329	516	10	516		516	22
23		3 Electric Water Heaters		2007	2,534	126	10	126		126	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.

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

See Page 12A, Line 70 for total

Facility Name & ID Number White Hall Nursing & Rehabilitation Center

0046896

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	TOTAL (lines 4 thru 69)	\$ 144,268	\$ 14,913		\$ 14,913	\$	\$ 22,535	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: 1/1/07 Ending: 12/31/07

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	\$ 106,812	\$ 18,927	\$ 18,927	\$		\$ 41,924	71
72	Current Year Purchases	22,363	1,988	1,988			1,989	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 129,175	\$ 20,915	\$ 20,915	\$		\$ 43,913	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	\$ 538	\$ 538	\$		\$ 1,346	76
77										77
78										78
79										79
80	TOTALS			\$ 1,615	\$ 538	\$ 538	\$		\$ 1,346	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)	\$	275,058	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	36,366	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	36,366	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)	\$	67,794	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	Architect Drawings	\$ 2,658	92
93	Phone System Upgrade	6,696	93
94			94
95		\$ 9,354	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: 1/1/07 Ending: 12/31/07

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

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>460,054</u>	<u>13.5 yrs</u>	<u>1-15 yrs</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		119		\$ 460,054			7

10. Effective dates of current rental agreement:

Beginning 12/31/2004 midnight

Ending 6/30/2018 midnight

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2008</u>	\$ <u>460,054</u>
13.	<u>12/31/2009</u>	\$ <u>460,054</u>
14.	<u>12/31/2010</u>	\$ <u>460,054</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 13.5 yrs.

104,578

1,411,803

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: \$ 33,102 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	<u>see separate schedule</u>		\$ _____	\$ <u>58</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 58	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center # 0046896 Report Period Beginning: 1/1/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 393,060	\$	1
2	Cash-Patient Deposits	9,161		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	759,041		3
4	Supply Inventory (priced at <u>cost</u>)	3,311		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,277		6
7	Other Prepaid Expenses	1,110,069		7
8	Accounts Receivable (owners or related parties)	(494,218)		8
9	Other(specify): <u>Non resident A/R(seeTB)</u>	274		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,782,975	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	134,644		15
16	Equipment, at Historical Cost	130,790		16
17	Accumulated Depreciation (book methods)	(63,612)		17
18	Deferred Charges	12,774		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Long Term Deposit</u>)	75		22
23	Other(specify): <u>Construction in Progress</u>	9,354		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 224,025	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,007,000	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 39,605	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,161		28
29	Short-Term Notes Payable	157,238		29
30	Accrued Salaries Payable	182,705		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,234		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,741		32
33	Accrued Interest Payable	2,885		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benefits Payable</u>	5,938		36
37	<u>Accrued Expenses</u>	312,733		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 802,240	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,678,279		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,678,279	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,480,519	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (473,519)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,007,000	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (457,238)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (457,238)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(16,281)	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)	\$ (16,281)	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)	\$ (473,519)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number White Hall Nursing & Rehabilitation Center# 0046896Report Period Beginning: 1/1/07Ending: 12/31/07**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,127,324	1
2	Discounts and Allowances for all Levels	1,050,931	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,178,255	3
B. Ancillary Revenue			
4	Day Care	1,485	4
5	Other Care for Outpatients		5
6	Therapy	230,181	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 231,666	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,847	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,504	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)	\$ 7,351	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,940	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,940	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	20,039	28
28a	Purchase Discounts / Sold Services Revenue	9,358	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,397	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,451,609	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	654,708	31
32	Health Care	1,750,325	32
33	General Administration	1,136,797	33
B. Capital Expense			
34	Ownership	735,095	34
C. Ancillary Expense			
35	Special Cost Centers	125,812	35
36	Provider Participation Fee	65,153	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,467,890	40
41	Income before Income Taxes (line 30 minus line 40)**	(16,281)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (16,281)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 1/1/07

Ending: 12/31/07

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	3,288	3,645	\$ 91,308	\$ 25.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,286	5,514	112,489	20.40	3
4	Licensed Practical Nurses	21,618	22,916	365,458	15.95	4
5	CNAs & Orderlies	56,056	60,404	535,513	8.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,619	1,795	19,854	11.06	9
10	Activity Assistants	1,740	1,756	12,951	7.38	10
11	Social Service Workers	1,881	2,113	20,689	9.79	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,081	26,181	12.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,640	10,565	80,501	7.62	15
16	Dishwashers	5,034	5,343	38,628	7.23	16
17	Maintenance Workers	2,029	2,145	26,148	12.19	17
18	Housekeepers	13,012	14,250	117,382	8.24	18
19	Laundry	2,263	2,374	18,240	7.68	19
20	Administrator	2,024	2,221	75,133	33.83	20
21	Assistant Administrator					21
22	Other Administrative	3,590	3,933	46,168	11.74	22
23	Office Manager	1,936	2,080	27,137	13.05	23
24	Clerical	165	206	1,670	8.11	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					31
32	Other Health Care MDS Coordinator	1,812	2,039	36,280	17.79	32
33	Other(specify) Nrsng Admin Cleric	3,018	3,370	38,565	11.44	33
34	TOTAL (lines 1 - 33)	137,923	148,750	\$ 1,690,295 *	\$ 11.36	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	9	\$ 555	1-3	35
36	Medical Director	contract	14,713	9-3	36
37	Medical Records Consultant	\$1/ bed	2,034	10-3	37
38	Nurse Consultant	0	0	0	38
39	Pharmacist Consultant	\$10/bed	14,280	10-3	39
40	Physical Therapy Consultant	0	0	0	40
41	Occupational Therapy Consultant	0	0	0	41
42	Respiratory Therapy Consultant	0	0	0	42
43	Speech Therapy Consultant	0	0	0	43
44	Activity Consultant	20	1,655	11-3	44
45	Social Service Consultant	20	1,655	12-3	45
46	Other(specify)	0	0	0	46
47	Medical Records Consultant				47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 34,892		49

C. CONTRACT NURSES

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

Facility Name & ID Number White Hall Nursing & Rehabilitation Center# 0046896Report Period Beginning: 1/1/07Ending: 12/31/07**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 \$4,631 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? _____
- (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. \$ 27,632 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? Y-DayCreRevOffset 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. \$ 2,847
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 \$5,000, 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.