

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0046896</u></p> <p>Facility Name: <u>White Hall Nrsg & Rehab Ctr</u></p> <p>Address: <u>620 W Bridgeport St</u> <u>White Hall</u> <u>62092</u> <small>Number City Zip Code</small></p> <p>County: <u>Greene</u></p> <p>Telephone Number: <u>(217) 374-2144</u> Fax # <u>(217) 374-6714</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>January 1, 2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Gary F. Eye</u> Telephone Number: <u>(716) 972-2392</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Gary F. Eye</u> (Title) <u>Senior VP of Finance of Tara Cares</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Gary F. Eye</u> (Title) <u>Senior VP of Finance of Tara Cares</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Gary F. Eye</u> (Title) <u>Senior VP of Finance of Tara Cares</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number White Hall Nrsng & Rehab Ctr

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

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	43,554	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	43,554	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,991	4,339	4,881	32,211	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,991	4,339	4,881	32,211	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.96%

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)

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 4,172

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number White Hall Nrsg & Rehab Ctr # 0046896 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	201,472	20,239	19,073	240,784		240,784	(480)	240,304		1
2	Food Purchase		196,954		196,954		196,954	(1,186)	195,768		2
3	Housekeeping	141,122	18,324	600	160,046		160,046		160,046		3
4	Laundry	45,807	9,872		55,679		55,679		55,679		4
5	Heat and Other Utilities			84,320	84,320		84,320	(440)	83,880		5
6	Maintenance	32,428	21,017	20,994	74,439		74,439	(73)	74,366		6
7	Other (specify):* see trial balance			21,707	21,707		21,707		21,707		7
8	TOTAL General Services	420,829	266,406	146,694	833,929		833,929	(2,179)	831,750		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,544,129	150,838	94,847	1,789,814		1,789,814	(9,647)	1,780,167		10
10a	Therapy		4,366	821,940	826,306		826,306	(24,230)	802,076		10a
11	Activities	50,897	1,908	2,506	55,311		55,311		55,311		11
12	Social Services	49,843	1,004	1,700	52,547		52,547		52,547		12
13	CNA Training										13
14	Program Transportation			11,049	11,049		11,049		11,049		14
15	Other (specify):* see trial balance			13,287	13,287		13,287	(5,713)	7,574		15
16	TOTAL Health Care and Programs	1,644,869	158,116	960,929	2,763,914		2,763,914	(39,590)	2,724,324		16
	C. General Administration										
17	Administrative	220,369		251,868	472,237		472,237	(20,185)	452,052		17
18	Directors Fees										18
19	Professional Services			71,094	71,094		71,094	(5,344)	65,750		19
20	Dues, Fees, Subscriptions & Promotions			34,168	34,168		34,168	(12,913)	21,255		20
21	Clerical & General Office Expenses	26,829	47,900	29,992	104,721		104,721	(10,761)	93,960		21
22	Employee Benefits & Payroll Taxes			638,554	638,554		638,554	(280)	638,274		22
23	Inservice Training & Education										23
24	Travel and Seminar			40,039	40,039		40,039	(166)	39,873		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			169,715	169,715		169,715	(2,600)	167,115		26
27	Other (specify):* see trial balance			112,017	112,017		112,017	(69,444)	42,573		27
28	TOTAL General Administration	247,198	47,900	1,347,447	1,642,545		1,642,545	(121,693)	1,520,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,312,896	472,422	2,455,070	5,240,388		5,240,388	(163,462)	5,076,926		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 Nrsg & Rehab Ctr

#0046896

Report Period Beginning:

1/1/12

Ending:

12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,931	11,931		11,931	76,513	88,444			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,317	4,317		4,317	21,692	26,009			32
33	Real Estate Taxes			77,776	77,776		77,776		77,776			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			29,406	29,406		29,406		29,406			35
36	Other (specify):*											36
37	TOTAL Ownership			363,430	363,430		363,430	(141,795)	221,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,329	4,329		4,329		4,329			39
40	Barber and Beauty Shops			725	725		725		725			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,691	235,691		235,691		235,691			42
43	Other (specify):* see trial balance			157,030	157,030		157,030	(43,878)	113,152			43
44	TOTAL Special Cost Centers			397,775	397,775		397,775	(43,878)	353,897			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,312,896	472,422	3,216,275	6,001,593		6,001,593	(349,135)	5,652,458			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,062)	2		4
5	Telephone, TV & Radio in Resident Rooms	(440)	5		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	(4,061)	32		10
11	Discounts, Allowances, Rebates & Refunds	(88)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(124)	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)	10		18
19	Entertainment				19
20	Contributions	(746)	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	(77,296)	27		24
25	Fund Raising, Advertising and Promotional	(12,913)	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	(34,231)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,964)		\$	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)	(218,171)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (218,171)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (349,135)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

White Hall Nrsg & Rehab Ctr

ID# 0046896

Report Period Beginning: 1/1/12

Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss-Other Supplies	\$ (10,652)	21	1
2	Remove non-allowable Visa Cost	(166)	24	2
3	Remove non-allowable Insurance Cost	(2,600)	26	3
4	Remove non-allowable Nrsg Admin-Purch Svcs	(3,645)	15	4
5	Remove non-allowable Admin-Other Purch Svcs	(5,298)	27	5
6	Remove non-allowable Med Records-Consulting	49	10	6
7	Remove non-allowable Outpatient Svcs-Consol Billing	(1,494)	43	7
8	Remove non-allowable BO-Tax Prep Fees	(5,344)	19	8
9	Remove non-allowable IV Prescription Drugs	(3,620)	43	9
10	Remove non-allowable Prior Year Costs	(3,491)	43	10
11	Offset Interco Sold Service Rev Sch XVII ln 28a	(480)	1	11
12	Offset Interco Sold Service Rev Sch XVII ln 28a	(96)	22	12
13	Offset Misc. Revenue Sch XVII line 28a	(1,271)	10	13
14	Offset Misc. Revenue Sch XVII line 28a	(16)	10	14
15	Offset Misc. Revenue Sch XVII line 28a	(73)	6	15
16	Offset Misc. Revenue Sch XVII line 28a	(660)	10	16
17	Offset Misc. Revenue Sch XVII line 28a	(44)	10	17
18	Offset Misc. Revenue Sch XVII line 28a	(21)	21	18
19	Amort/Depreciate Repair/Maint Captl. For Medicaid	4,691	30	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	Total	(34,231)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(480)	0	0	0	0	0	0	0	0	0	0	(480)	1
2	Food Purchase	(1,186)	0	0	0	0	0	0	0	0	0	0	(1,186)	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	(440)	0	0	0	0	0	0	0	0	0	0	(440)	5
6	Maintenance	(73)	0	0	0	0	0	0	0	0	0	0	(73)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,179)	0	0	0	0	0	0	0	0	0	0	(2,179)	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	(1,945)	(7,702)	0	0	0	0	0	0	0	0	0	(9,647)	10
10a	Therapy	0	(24,230)	0	0	0	0	0	0	0	0	0	(24,230)	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):*	(3,645)	(2,068)	0	0	0	0	0	0	0	0	0	(5,713)	15
16	TOTAL Health Care and Programs	(5,590)	(34,000)	0	0	0	0	0	0	0	0	0	(39,590)	16
	C. General Administration													
17	Administrative	0	(20,185)	0	0	0	0	0	0	0	0	0	(20,185)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,344)	0	0	0	0	0	0	0	0	0	0	(5,344)	19
20	Fees, Subscriptions & Promotions	(12,913)	0	0	0	0	0	0	0	0	0	0	(12,913)	20
21	Clerical & General Office Expenses	(10,761)	0	0	0	0	0	0	0	0	0	0	(10,761)	21
22	Employee Benefits & Payroll Taxes	(96)	(184)	0	0	0	0	0	0	0	0	0	(280)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(166)	0	0	0	0	0	0	0	0	0	0	(166)	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):*	(83,340)	0	13,896	0	0	0	0	0	0	0	0	(69,444)	27
28	TOTAL General Administration	(115,220)	(20,369)	13,896	0	(121,693)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(122,989)	(54,369)	13,896	0	(163,462)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nrsg & Rehab Ctr # 0046896 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,691	0	71,822	0	0	0	0	0	0	0	0	76,513	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,061)	0	25,753	0	0	0	0	0	0	0	0	21,692	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(240,000)	0	0	0	0	0	0	0	0	(240,000)	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	630	0	(142,425)	0	(141,795)	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):*	(8,605)	(35,273)	0	0	0	0	0	0	0	0	0	(43,878)	43
44	TOTAL Special Cost Centers	(8,605)	(35,273)	0	0	0	0	0	0	0	0	0	(43,878)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(130,964)	(89,642)	(128,529)	0	(349,135)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>DTD HC, LLC</u>	<u>50%</u>	<u>Granite Nursing and Rehabilitation Center, LLC</u>	<u>Granite City</u>	<u>Colonnades Property Co</u>	<u>Granite City</u>	<u>Property Company</u>
<u>D & N, LLC</u>	<u>50%</u>	<u>Stearns Nursing and Rehabilitation Center, LLC</u>	<u>Granite City</u>	<u>Stearns Property Com</u>	<u>Granite City</u>	<u>Property Company</u>
		<u>Calhoun Nursing and Rehabilitation Center, LLC</u>	<u>Hardin</u>	<u>Hardin Property Com</u>	<u>Hardin</u>	<u>Property Company</u>
		<u>Scenic Nursing and Rehabilitation Center, LLC</u>	<u>Herculaneum</u>	<u>Herculaneum Property</u>	<u>Herculaneum</u>	<u>Property Company</u>
		<u>Jefferson City Nursing & Rehabilitation Center, LLC</u>	<u>Jefferson City</u>	<u>Jefferson City Propert</u>	<u>Jefferson City</u>	<u>Property Company</u>
		<u>Riverside Nursing and Rehabilitation Center, LLC</u>	<u>Kansas City</u>	<u>Riverside Property Co</u>	<u>Kansas City</u>	<u>Property Company</u>
		<u>Douglasville Nursing & Rehabilitation Center, LLC</u>	<u>Douglasville</u>	<u>Terrace Square (Doug</u>	<u>Douglasville</u>	<u>Property Company</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	Administrative Services Costs	\$ 251,868	Aurora Cares, LLC d/b/a Tara Cares	0.00%	\$ 231,683	\$ (20,185)	1
2	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	1,532	(2,068)	2
3	V	10	Pharmacy Consulting Services	25,704	Tara Pharmacy SE, LLC	0.00%	21,065	(4,639)	3
4	V	10	Medical Administration Records	7,854	Tara Pharmacy SE, LLC	0.00%	4,791	(3,063)	4
5	V	43	FluVac/Prescription Drug-Residents	131,621	Tara Pharmacy SE, LLC	0.00%	96,348	(35,273)	5
6	V	22	Flu & TB Vaccines for Employees	2,391	Tara Pharmacy SE, LLC	0.00%	2,207	(184)	6
7	V	10a	Physical Therapy Fees	360,821	Tara Therapy, LLC	0.00%	353,658	(7,163)	7
8	V	10a	Occupational Therapy Fees	321,029	Tara Therapy, LLC	0.00%	273,149	(47,880)	8
9	V	10a	Speech Therapy Fees	140,090	Tara Therapy, LLC	0.00%	170,903	30,813	9
10	V	15	Nursing Service	155	Granite Nursing and Rehabilitation Center, LLC	0.00%	155		10
11	V	1	Dietary Service	12,849	Scenic Nursing and Rehabilitation Center, LLC	0.00%	12,849		11
12	V	1	Dietary Service	2,020	Stearns Nursing and Rehabilitation Center, LLC	0.00%	2,020		12
13	V	15	Nursing Service	1,029	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	1,029		13
14	Total		\$ 1,261,031				\$ 1,171,389	\$ * (89,642)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent	\$ 240,000	White Hall Property Company, LLC	0.00%	\$	\$ (240,000)
16	V	27 Admin-Other Purch Svcs		White Hall Property Company, LLC	0.00%	60	60
17	V	30 Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	37,667	37,667
18	V	30 Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	28,229	28,229
19	V	30 Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	5,926	5,926
20	V	27 Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	13,836	13,836
21	V	32 Interest-Capital/Long-Term Debt		White Hall Property Company, LLC	0.00%	25,753	25,753
22	V	6 Maintenance Service	382	Stearns Nursing and Rehabilitation Center, LLC	0.00%	382	
23	V	27 Administrative Service	244	Stearns Nursing and Rehabilitation Center, LLC	0.00%	244	
24	V	10 LPN Service	225	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	225	
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 240,851			\$ 112,322	\$ * (128,529)

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

Facility Name & ID Number

White Hall Nrsg & Rehab Ctr

0046896

Report Period Beginning:

1/1/12

Ending:

12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Jonesboro Nursing and Rehabilitation Center, L	Jonesboro	Jonesboro Property Co	Jonesboro	Property Company	1
2			Lake City Nursing and Rehabilitation Center, L	Lake City	Rex Road Property Co	Lake City	Property Company	2
3			Mobile Nursing and Rehabilitation Center, LLC	Mobile	Mobile Property Com	Mobile	Property Company	3
4			Fairfield Nursing and Rehabilitation Center, LL	Fairfield	Fairfield Property Cor	Fairfield	Property Company	4
5			Florence Nursing and Rehabilitation Center, LL	Florence	Florence Property Cor	Florence	Property Company	5
6			Birmingham Nrs&Rehab Center East, LLC	Birmingham	Birmingham East Prop	Birmingham	Property Company	6
7			Birmingham Nursing and Rehabilitation Center	Birmingham	Birmingham Property	Birmingham	Property Company	7
8			Eight Mile Nursing and Rehabilitation Center, I	Eight Mile	Eight Mile Property C	Eight Mile	Property Company	8
9			Quince Nursing and Rehabilitation Center, LLC	Memphis	Quince Property Com	Memphis	Property Company	9
10			Allenbrooke Nursing and Rehabilitation Center,	Memphis	Allenbrooke Property	Memphis	Property Company	10
11			Tupelo Nursing and Rehabilitation Center, LLC	Tupelo	Tupelo Property Com	Tupelo	Property Company	11
12			Brandon Nursing and Rehabilitation Center, LL	Brandon	Brandon Property Cor	Brandon	Property Company	12
13			Lakeland Nursing and Rehabilitation Center, LJ	Jackson	Lakeland Property Co	Jackson	Property Company	13
14			McComb Nursing and Rehabilitation Center, LI	McComb	McComb Property Co	McComb	Property Company	14
15			Cleveland Nursing and Rehabilitation Center, L	Cleveland	Cleveland Property Co	Cleveland	Property Company	15
16			Chadwick Nursing and Rehabilitation Center, L	Jackson	Chadwick (Jackson) P	Jackson	Property Company	16
17			Manhattan Nursing and Rehabilitation Center, J	Jackson	Manhattan Property C	Jackson	Property Company	17
18			Ruleville Nursing and Rehabilitation Center, LL	Ruleville	Ruleville Property Cor	Ruleville	Property Company	18
19			Farmerville Nursing and Rehabilitation Center,	Farmerville	Farmerville Property C	Farmerville	Property Company	19
20			Bernice Nursing and Rehabilitation Center, LLC	Bernice	Bernice Property Com	Bernice	Property Company	20
21			Ruston Nursing and Rehabilitation Center, LLC	Ruston	Longleaf (Ruston) Pro	Ruston	Property Company	21
22			Natchitoches Nursing and Rehabilitation Center	Natchitoches	Natchitoches Property	Natchitoches	Property Company	22
23			Winnfield Nursing and Rehabilitation Center, L	Winnfield	Winnfield Property Co	Winnfield	Property Company	23
24			Ringgold Nursing and Rehabilitation Center, LI	Ringgold	Ringgold Property Co	Ringgold	Property Company	24
25			Arcadia Nursing and Rehabilitation Center, LL	Arcadia	Willow Ridge (Arcadia	Arcadia	Property Company	25
26			Jena Nursing and Rehabilitation Center, LLC	Jena	Aimwell (Jena) Proper	Jena	Property Company	26
27					Aurora Cares Property	Orchard Park	Property Company	27
28			** The above listed facilities are related by		Aurora Cares, LLC d/	Orchard Park	Support Office	28
29			common ownership		Tara Midwest, LLC	Orchard Park	Clearing Account fo	29
30					Tara Healthcare, LLC	Orchard Park	Clearing Account fo	30

Facility Name & ID Number

White Hall Nrsg & Rehab Ctr

0046896

Report Period Beginning:

1/1/12

Ending:

12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Tara Pharmacy SE, L	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	4
5					3690 N. H. Associates,	Orchard Park	Clearing Account fo	5
6					3690 Associates, LLC	Orchard Park	Clearing Account fo	6
7					Health Care Risk Gro	Orchard Park	Insurance	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number White Hall Nrsg & Rehab Ctr # 0046896 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	\$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.69	1.73	Fin/ Adm. TC	4,842	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CEO for Tara Cares	Finance/ Admin	0.00	***	0.69	1.73	Fin/ Adm. TC	4,842	17	5
6			of Tara Cares								6
7	Suzette Wilson	Vice President		0.00	***	0.69	1.73	VP	4,018	17	7
8											8
9	*** Compensation paid only through Support Office and allocated share reported in column 7.										9
10											10
11											11
12											12
13								TOTAL	\$ 13,702		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 Nrsg & Rehab Ctr

0046896

Report Period Beginning:

1/1/12

Ending: 12/31/12

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 PO Box 428
 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	1	Administrative Services Costs	Days	1,473,669	35	\$ 257,223	\$ 220,671	\$ 32,199	\$ 5,620	1
2	5	Administrative Services Costs	Days	1,473,669	35	36,825	0	32,199	805	2
3	6	Administrative Services Costs	Days	1,473,669	35	55,513	0	32,199	1,213	3
4	10	Administrative Services Costs	Days	1,473,669	35	2,440,929	2,173,122	32,199	53,335	4
5	17	Administrative Services Costs	Days	1,473,669	35	5,663,604	5,663,604	32,199	123,749	5
6	19	Administrative Services Costs	Days	1,473,669	35	9,265	0	32,199	202	6
7	20	Administrative Services Costs	Days	1,473,669	35	14,781	0	32,199	323	7
8	21	Administrative Services Costs	Days	1,473,669	35	305,257	0	32,199	6,671	8
9	22	Administrative Services Costs	Days	1,473,669	35	1,272,672	0	32,199	27,807	9
10	24	Administrative Services Costs	Days	1,473,669	35	113,930	0	32,199	2,489	10
11	26	Administrative Services Costs	Days	1,473,669	35	5,104	0	32,199	112	11
12	27	Administrative Services Costs	Days	1,473,669	35	133,549	0	32,199	2,918	12
13	30	Administrative Services Costs	Days	1,473,669	35	154,779	0	32,199	3,382	13
14	31	Administrative Services Costs	Days	1,473,669	35	4,919	0	32,199	107	14
15	32	Administrative Services Costs	Days	1,473,669	35	91	0	32,199	2	15
16	33	Administrative Services Costs	Days	1,473,669	35	28,086	0	32,199	614	16
17	34	Administrative Services Costs	Days	1,473,669	35	106,649	0	32,199	2,330	17
18	35	Administrative Services Costs	Days	1,473,669	35	173	0	32,199	4	18
19										19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.								22
23										23
24										24
25	TOTALS					\$ 10,603,349	\$ 8,057,397		\$ 231,683	25

Facility Name & ID Number

White Hall Nrsg & Rehab Ctr

0046896

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	M&T BANK		X	Purchase of Physical Plant	\$1,028.00	6/22/11	\$ 345,241	\$	6/20/12	libor+3.5%	\$ 5,138	1						
2	M&T BANK		X	Refinance Purchase of Plant	\$2,945.00	6/20/12	935,293		12/20/12	libor+3.5%	20,616	2						
3												3						
4												4						
5												5						
Working Capital																		
6	M&T BANK		X	Working Capital-Floating Balan	\$301.00	6/20/12	3,789	152,714	Demand not	0.0450	3,611	6						
7												7						
8												8						
9	TOTAL Facility Related				\$4,274.00		\$ 1,284,323	\$ 152,714			\$ 29,365	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,284,323	\$ 152,714			\$ 29,365	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2011 report.				\$	77,480	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	75,736	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,744)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	79,520	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.				\$	77,776	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2007	69,507	8	FOR BHF USE ONLY			
	2008	70,837	9	13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
	2009	69,662	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2010	73,796	11	15	LESS REFUND FROM LINE 6	\$	15
	2011	75,736	12	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nrsg & Rehab Ctr COUNTY Greene

FACILITY IDPH LICENSE NUMBER 0046896

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-53-34-400-002</u>	<u>620 W. Bridgeport</u>	\$ <u>75,735.60</u>	\$ <u>75,735.60</u>
2. _____	<u>3W JC 536</u>	\$ _____	\$ _____
3. _____	<u>34-12-12</u>	\$ _____	\$ _____
4. _____	<u>PT N MID PT E1/2 SE</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>75,735.60</u></u>	\$ <u><u>75,735.60</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Nrsg & Rehab Ctr

0046896 Report Period Beginning:

1/1/12 Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,835 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).

N/A

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: 131,730 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.CapitalizedPre-openingSalaries,Benefits&OtherCostsIncurred2007,2009&2010.AllocatedViaRelatedOrgCost&ReportedSchVII B
(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	<u>Long Term Care</u>	<u>209,829</u>	<u>2011</u>	<u>\$ 19,707</u>	1
2					2
3	TOTALS	209,829		\$ 19,707	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	119	2011	1972	\$ 237,024	\$ 5,926	40	\$ 5,926	\$	\$ 8,888	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Alumalite Sign		2005	797	80	10	80		598	9
10	Generator Repairs, capitalized for Medicaid		2005	2,270		3			2,270	10
11	Auto Cad Design for Fire Alarm System		2006	1,080	108	10	108		702	11
12	Sign Pillars w/ Lighting		2006	8,975	898	10	898		5,835	12
13	Telewiring - Computer Outlets (2)		2006	1,473	37	40	37		239	13
14	Window Treatment		2006	13,663	1,366	10	1,366		8,881	14
15	Shower Room Renovations		2006	46,015	3,834	12	3,834		24,924	15
16	Measure & Install Blinds in Facility		2006	10,998		5			10,998	16
17	Handrail and Background Staining		2006	14,880	1,240	12	1,240		8,060	17
18	Electrical Wiring (lighting & smoke detectors)		2006	23,000	1,917	12	1,917		12,459	18
19	Concrete Sidewalk		2006	900	75	12	75		488	19
20	Sprinkler System Repairs, capitalized for Medicaid		2006	3,194		3			3,194	20
21	Installation of Data Outlet Recepticles for Medicaid		2007	4,160		3			4,160	21
22	Dry Wall - Entire Building		2007	10,329	1,033	10	1,033		5,681	22
23	3 Electric Water Heaters		2007	2,534	253	10	253		1,393	23
24	Phone System		2008	13,533	1,353	10	1,353		6,089	24
25	Metal Fire Door		2008	1,825	182	10	182		821	25
26	Paging System		2008	2,036	204	10	204		917	26
27	Dishmachine		2008	16,636	1,664	10	1,664		7,487	27
28	Smoke Detectors		2008	3,125	312	10	312		1,406	28
29	Window replacement (windows, sills, trim)		2009	40,527	4,503	9	4,503		15,761	29
30	Nurse Station		2009	56,951	6,328	9	6,328		22,148	30
31	Tile Floor		2009	13,887	1,543	9	1,543		5,400	31
32	Cabinet		2009	649	72	9	72		252	32
33	Electrical work (therapy kitchen)		2009	1,950	217	9	217		759	33
34	A/C Roof Unit Repair - capitalized for Medicaid		2009	2,948	491	3	491		2,948	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tank Heater	2010	\$ 1,324	\$ 165	8	\$ 165	\$	\$ 413	37
38	A/C Units (4)	2010	2,099	420	5	420		1,050	38
39	A/C Units (3)	2010	1,626	203	8	203		508	39
40	Sewage Pump w/ Sump Pump	2010	637	80	8	80		199	40
41	A/C Unit	2010	538	108	5	108		269	41
42	Walk-In Freezer	2010	12,075	1,509	8	1,509		3,773	42
43	Repairs incurred from Lightning Strike - capitalized for Medicaid	2010	10,000	3,333	3	3,333		8,333	43
44	Water Softener System	2011	4,233	605	7	605		907	44
45	A/C Unit (5)	2011	2,688	538	5	538		807	45
46	Window Replacement	2011	47,741	6,820	7	6,820		10,230	46
47	Parking Lot Repairs capitalized for Medicaid	2011	2,600	867	3	867		1,300	47
48	Fencing around the dumpster	2012	1,199	75	8	75		75	48
49	A/C Units (4)	2012	2,372	237	5	237		237	49
50	Air Curtain	2012	721	24	15	24		24	50
51	Built-in AC Units (2)	2012	1,186	118	5	118		118	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59	Note: See additional building improvements made by former								59
60	property owner Healthcare REIT, Inc. on supplemental								60
61	schedule included as page 24 of the cost report.								61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 626,398	\$ 48,738		\$ 48,738	\$	\$ 191,001	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 193,393	\$ 30,428	\$ 30,428	\$	various	\$ 106,474	71
72	Current Year Purchases	32,969	1,943	1,943		various	1,943	72
73	Fully Depreciated Assets	63,565				various	63,564	73
74								74
75	TOTALS	\$ 289,927	\$ 32,371	\$ 32,371	\$		\$ 171,981	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Long Term Care	2009 Ford F250 Extended Wheel	2009	\$ 36,675	\$ 7,335	\$ 7,335	\$	5	\$ 25,673	76
77										77
78										78
79										79
80	TOTALS			\$ 36,675	\$ 7,335	\$ 7,335	\$		\$ 25,673	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)	\$ 972,707	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,444	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)	\$ 388,655	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect-Therapy Reno	\$ 11,483	92
93	Flooring- Lounge&Dining Room	5,982	93
94			94
95		\$ 17,465	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

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

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

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

9. Option to Buy: YES NO Terms: N/A *

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: \$ 28,207 Description: see separate schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2013 \$ N/A

13. /2014 \$ N/A

14. /2015 \$ N/A

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

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,898	\$	1
2	Cash-Patient Deposits	22,322		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,246,673		3
4	Supply Inventory (priced at <u>cost</u>)	7,444		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,679		6
7	Other Prepaid Expenses	6,192		7
8	Accounts Receivable (owners or related parties)	(2,813,232)		8
9	Other(specify): <u>Non resident A/R (see TB)</u>	3,326		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,521,698)	\$	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	5,477		15
16	Equipment, at Historical Cost	80,736		16
17	Accumulated Depreciation (book methods)	(31,368)		17
18	Deferred Charges	2,118		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(1,448)		21
22	Other Long-Term Assets (specify):	1,175		22
23	Other(specify): <u>Construction In Progress</u>	17,465		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 74,155	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,447,543)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 98,960	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,322		28
29	Short-Term Notes Payable	152,714		29
30	Accrued Salaries Payable	217,584		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,003		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,520		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Benefits Payable</u>	3,153		36
37	<u>Accrued Expenses</u>	666,508		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,264,764	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,264,764	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,712,307)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,447,543)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,198,256)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,198,256)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(415,051)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	39,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(138,000)	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)	\$ (514,051)	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)	\$ (2,712,307)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number White Hall Nrsg & Rehab Ctr# 0046896Report Period Beginning: 1/1/12Ending: 12/31/12**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,009,043	1
2	Discounts and Allowances for all Levels	685,113	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,694,156	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	719,882	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 719,882	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	1,062	14
15	Telephone, Television and Radio	440	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,331	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,080	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,913	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,061	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,061	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	158,075	28
28a	Purchase Discounts & Misc Revenue	5,455	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 163,530	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,586,542	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	833,929	31
32	Health Care	2,763,914	32
33	General Administration	1,642,545	33
B. Capital Expense			
34	Ownership	363,430	34
C. Ancillary Expense			
35	Special Cost Centers	162,084	35
36	Provider Participation Fee	235,691	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,001,593	40
41	Income before Income Taxes (line 30 minus line 40)**	(415,051)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (415,051)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,239,229	44
45	Private Pay - Net Inpatient Revenue	554,637	45
46	Medicare - Net Inpatient Revenue	1,835,340	46
47	Other-(specify) <u>Hospice Contract</u>	64,950	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,694,156	49

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

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

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

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

Facility Name & ID Number White Hall Nrsg & Rehab Ctr

0046896

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	1,944	2,113	\$ 88,638	\$ 41.95	1
2	Assistant Director of Nursing	1,488	2,034	40,802	20.06	2
3	Registered Nurses	6,927	7,400	160,909	21.74	3
4	Licensed Practical Nurses	21,347	23,310	446,559	19.16	4
5	CNAs & Orderlies	59,098	65,684	659,719	10.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,938	2,214	31,626	14.28	9
10	Activity Assistants	1,920	2,147	19,271	8.98	10
11	Social Service Workers	2,856	3,136	49,843	15.89	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,037	45,194	22.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,976	9,903	89,448	9.03	15
16	Dishwashers	6,915	7,787	66,830	8.58	16
17	Maintenance Workers	1,903	2,312	32,428	14.03	17
18	Housekeepers	12,531	14,049	141,122	10.04	18
19	Laundry	4,744	5,458	45,807	8.39	19
20	Administrator	1,968	1,984	102,112	51.47	20
21	Assistant Administrator					21
22	Other Administrative	3,328	3,937	58,178	14.78	22
23	Office Manager	1,904	2,080	37,715	18.13	23
24	Clerical	4,113	4,469	49,193	11.01	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(specify)	4,808	5,291	115,942	21.91	32
33	Other(specify)	2,249	2,585	31,560	12.21	33
34	TOTAL (lines 1 - 33)	152,861	169,930	\$ 2,312,896 *	\$ 13.61	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	176	15,600	9-3	36
37	Medical Records Consultant	17	585	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18 per bed/mo	25,704	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,700	11-3	44
45	Social Service Consultant	30	1,700	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	\$5.50 per bed/mo	7,854	10-3	47
48					48
49	TOTAL (lines 35 - 48)	253	\$ 53,143		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	129	\$ 7,334	10-3	50
51	Licensed Practical Nurses	459	15,807	10-3	51
52	Certified Nurse Assistants/Aides	1,731	37,337	10-3	52
53	TOTAL (lines 50 - 52)	2,319	\$ 60,478		53

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
FY2007					FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

Report Period Beginning:

1/1/12

Ending:

12/31/12**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 \$2,152 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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,716 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 235,691
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. \$ 1,062
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No personal use
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC

0046896

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Improvements Made by Health Care REIT (covered by rent at outset		\$	\$		\$	\$	\$	1
2	of Change of Ownership):								2
3									3
4	Ductwork	2005	65,173	3,259	20	3,259		24,440	4
5	EPDM Roof System	2005	213,004	21,300	10	21,300		159,753	5
6	Fire Alarm System	2005	30,608	3,061	10	3,061		22,956	6
7	Service Doors (2), Break Room Door (1)	2005	4,650	358	13	358		2,683	7
8	Drywall seven (7) rooms	2005	1,983	153	13	153		1,144	8
9	A/C Units	2006	18,612	0	5	0		18,612	9
10	Installation of Fire Alarm System	2006	1,820	182	10	182		1,183	10
11	Chair Rails	2006	2,380	198	12	198		1,289	11
12	Paint Ceilings in Resident Rooms	2006	3,825	0	5	0		3,825	12
13	Wall Repair and Painting of Facility	2006	55,141	0	5	0		55,141	13
14	A/C Unit 5 Ton	2006	3,600	360	10	360		2,340	14
15	Landscaping	2006	9,979	998	10	998		6,486	15
16	Sprinkler System	2006	169,310	14,109	12	14,109		91,710	16
17	Suspend Ceiling	2006	46,322	3,860	12	3,860		25,061	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 626,406	\$ 47,838		\$ 47,838	0	\$ 416,623	34

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