

Facility Name & ID Number White Hall Nsg & Rehab Ctr

0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	26,079	8,230	5,388	39,697	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,079	8,230	5,388	39,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.14%

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)
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 4,430

Medicare Intermediary Wisconsin Physicians Insurance Corp (WSP)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 1/1 to 12/31/16 Fiscal Year: 1/1 to 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
1	A. General Services										
1	Dietary	237,430	22,717	15,025	275,172		275,172	20	275,192		1
2	Food Purchase		248,881		248,881		248,881	(3,233)	245,648		2
3	Housekeeping	161,819	20,639	40	182,498		182,498	(233)	182,265		3
4	Laundry	62,335	11,698		74,033		74,033	(439)	73,594		4
5	Heat and Other Utilities			108,305	108,305		108,305		108,305		5
6	Maintenance	54,374	42,066	34,312	130,752		130,752	(12,226)	118,526		6
7	Other (specify):* see trial balance			15,705	15,705		15,705		15,705		7
8	TOTAL General Services	515,958	346,001	173,387	1,035,346		1,035,346	(16,111)	1,019,235		8
9	B. Health Care and Programs										
9	Medical Director			16,068	16,068		16,068		16,068		9
10	Nursing and Medical Records	2,109,623	205,516	71,377	2,386,516		2,386,516	(10,872)	2,375,644		10
10a	Therapy		6,413	978,519	984,932		984,932	(169,821)	815,111		10a
11	Activities	70,774	5,338	2,886	78,998		78,998	300	79,298		11
12	Social Services	86,650	1,463	2,295	90,408		90,408	288	90,696		12
13	CNA Training			916	916		916		916		13
14	Program Transportation			37,312	37,312		37,312	(3,458)	33,854		14
15	Other (specify):* see trial balance			14,396	14,396		14,396	(6,836)	7,560		15
16	TOTAL Health Care and Programs	2,267,047	218,730	1,123,769	3,609,546		3,609,546	(190,399)	3,419,147		16
17	C. General Administration										
17	Administrative	281,617		387,132	668,749		668,749	(133,235)	535,514		17
18	Directors Fees										18
19	Professional Services			45,469	45,469		45,469	(2,438)	43,031		19
20	Dues, Fees, Subscriptions & Promotions			53,286	53,286		53,286	(33,880)	19,406		20
21	Clerical & General Office Expenses		82,416	69,508	151,924		151,924	(23,144)	128,780		21
22	Employee Benefits & Payroll Taxes			494,326	494,326		494,326	1,572	495,898		22
23	Inservice Training & Education										23
24	Travel and Seminar			25,564	25,564		25,564		25,564		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,762	96,762		96,762	(2,600)	94,162		26
27	Other (specify):* see trial balance			262,872	262,872		262,872	(249,903)	12,969		27
28	TOTAL General Administration	281,617	82,416	1,434,919	1,798,952		1,798,952	(443,628)	1,355,324		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,064,622	647,147	2,732,075	6,443,844		6,443,844	(650,138)	5,793,706		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 Nsg & Rehab Ctr

#0046896

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	
30	D. Ownership Depreciation			217,889	217,889	217,889	60,301	278,190			30	
31	Amortization of Pre-Op. & Org.										31	
32	Interest						339,557	339,557			32	
33	Real Estate Taxes			149,032	149,032	149,032		149,032			33	
34	Rent-Facility & Grounds			820,800	820,800	820,800	(820,800)				34	
35	Rent-Equipment & Vehicles			41,617	41,617	41,617	309	41,926			35	
36	Other (specify):* Off Site Storage			752	752	752		752			36	
37	TOTAL Ownership			1,230,090	1,230,090	1,230,090	(420,633)	809,457			37	
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportator										38	
39	Ancillary Service Centers										39	
40	Barber and Beauty Shops										40	
41	Coffee and Gift Shops										41	
42	Provider Participation Fee			280,009	280,009	280,009		280,009			42	
43	Other (specify):* see trial balance			263,336	263,336	263,336	(89,477)	173,859			43	
44	TOTAL Special Cost Centers			543,345	543,345	543,345	(89,477)	453,868			44	
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,064,622	647,147	4,505,510	8,217,279	8,217,279	(1,160,248)	7,057,031			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	(2,945)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(89)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(236)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(257,455)	27		24
25	Fund Raising, Advertising and Promotional	(30,676)	20		25
	Income Taxes and Illinois Persona				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(261,468)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (554,299)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization & Pre-Operating Expense			
33				33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(605,949)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (605,949)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,160,248)		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

White Hall Nsg & Rehab Ctr

ID# 0046896

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues&Subscriptions	\$ (3,028)	20	1
2	Remove Non-allowable Admiss Dues & Subscriptions	(135)	20	2
3	Remove Non-allowable Admissions Other Supplies	(19,294)	21	3
4	Remove Non-allowable Dental - Physician Fees	(4,844)	43	4
5	Remove Non-allowable Insurance Cost	(2,600)	26	5
6	Remove Non-allowable Admin Other Supplies	(620)	21	6
7	Remove Non-allowable NRS Admin - Rental/Lease	(1)	35	7
8	Remove Non-allowable Finance Charges	(414)	21	8
9	Remove Non-allow Admin - Other Purchased Svcs	(1,289)	27	9
10	Remove Non-allowable Admiss-Rental/Lease	(100)	35	10
11	Remove Non-allowable NRS Admin- Res Transport	(3,458)	14	11
12	Remove Non-allowable HR-EE background checks	(41)	20	12
13	Remove Non-allowable BO Tax Preperation Fees	(2,438)	19	13
14	Remove Non-allow Outpatient Svcs-consol billing	(465)	43	14
15	Additional Allowable Dietary	20	1	15
16	Additional Allowable Food	(52)	2	16
17	Additional Allowable Maintenance	(1,599)	6	17
18	Additional Allowable Laundry	(439)	4	18
19	Additional Allowable Nursing and Med. Records	1,114	10	19
20	Additional Allowable Activities	300	11	20
21	Additional Allowable Social Services	288	12	21
22	Additional Allowable Therapy	35	10a	22
23	Additional Allow Clerical & General Office Exp	109	21	23
24	Additional Allowable EE Benefits	1,890	22	24
25	Additional Allowable Rent - Equipment	410	35	25
26	Additional Allowable ADR submission	10	27	26
27	Remove Non-allowable IV Rx Drugs Cost	(2,687)	43	27
28	Remove Non-allowable Prior Year Costs	(6,887)	43	28
29	Offset Interco Sold Services Revenue	(905)	6	29
30	Offset Interco Sold Services Revenue	(250)	17	30
31	Offset Interco Sold Services Revenue	(138)	17	31
32	Offset Interco Sold Services Revenue	(897)	17	32
33	Offset Interco Sold Services Revenue	(655)	10	33
34	Offset Interco Sold Services Revenue	(233)	3	34
35	Offset Interco Sold Services Revenue	(413)	22	35
36	Offset Misc. Revenue Med Surg & Food Sup.	(1,833)	10	36
37	Offset Misc. Revenue Non-Med Equip	(136)	6	37
38	Offset Misc. Revenue Incontinent	(1,285)	10	38
39	Offset Misc. Revenue Equip	(14)	10	39
40	Offset Misc. Revenue Other	(11)	21	40
41	Capitalize repairs & Maintenance & Equipment	(10,152)	10	41
42	Capitalize repairs & Maintenance & Equipment	(9,586)	6	42
43	Depreciation/Amort LHI	3,921	30	43
44	Depreciation/Amort MME	6,697	30	44
45	Current Year Depreciation Audit Adjustments LHI	(2,909)	30	45
46	Offset Outpatient Physical Therapy Revenue	(148,845)	10a	46
47	Offset Outpatient Occupational Therapy Revenue	(45,126)	10a	47
48	Offset Outpatient Speech Therapy Revenue	(2,483)	10a	48
49	Total	(261,468)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896 Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	20	0	0	0	0	0	0	0	0	0	0	20	1
2	Food Purchase	(3,233)	0	0	0	0	0	0	0	0	0	0	(3,233)	2
3	Housekeeping	(233)	0	0	0	0	0	0	0	0	0	0	(233)	3
4	Laundry	(439)	0	0	0	0	0	0	0	0	0	0	(439)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(12,226)	0	0	0	0	0	0	0	0	0	0	(12,226)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,111)	0	0	0	0	0	0	0	0	0	0	(16,111)	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	(12,825)	1,953	0	0	0	0	0	0	0	0	0	(10,872)	10
10a	Therapy	(196,419)	26,598	0	0	0	0	0	0	0	0	0	(169,821)	10a
11	Activities	300	0	0	0	0	0	0	0	0	0	0	300	11
12	Social Services	288	0	0	0	0	0	0	0	0	0	0	288	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,458)	0	0	0	0	0	0	0	0	0	0	(3,458)	14
15	Other (specify):*	0	(6,836)	0	0	0	0	0	0	0	0	0	(6,836)	15
16	TOTAL Health Care and Programs	(212,114)	21,715	0	0	0	0	0	0	0	0	0	(190,399)	16
	C. General Administration													
17	Administrative	(1,285)	(131,950)	0	0	0	0	0	0	0	0	0	(133,235)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,438)	0	0	0	0	0	0	0	0	0	0	(2,438)	19
20	Fees, Subscriptions & Promotions	(33,880)	0	0	0	0	0	0	0	0	0	0	(33,880)	20
21	Clerical & General Office Expenses	(21,749)	(1,395)	0	0	0	0	0	0	0	0	0	(23,144)	21
22	Employee Benefits & Payroll Taxes	1,477	95	0	0	0	0	0	0	0	0	0	1,572	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(258,734)	0	8,831	0	0	0	0	0	0	0	0	(249,903)	27
28	TOTAL General Administration	(319,209)	(133,250)	8,831	0	(443,628)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(547,434)	(111,535)	8,831	0	(650,138)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2016 Ending:12/31/2016

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	7,709	0	52,592	0	0	0	0	0	0	0	0	60,301	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	339,557	0	0	0	0	0	0	0	0	339,557	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(820,800)	0	0	0	0	0	0	0	0	(820,800)	34
35	Rent-Equipment & Vehicles	309	0	0	0	0	0	0	0	0	0	0	309	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,018	0	(428,651)	0	(420,633)	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):*	(14,883)	(74,594)	0	0	0	0	0	0	0	0	0	(89,477)	43
44	TOTAL Special Cost Centers	(14,883)	(74,594)	0	0	0	0	0	0	0	0	0	(89,477)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(554,299)	(186,129)	(419,820)	0	(1,160,248)	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>Tara Pharmacy SE, L</u>	<u>Birmingham</u>	<u>Pharmacy</u>
<u>D & N, LLC</u>	<u>50%</u>	<u>Stearns Nursing and Rehabilitation Center, LLC</u>	<u>Granite City</u>	<u>Tara Therapy, LLC</u>	<u>Orchard Park</u>	<u>Therapy</u>
		<u>Calhoun Nursing and Rehabilitation Center, LLC</u>	<u>Hardin</u>	<u>Raimax Healthcare So</u>	<u>Orchard Park</u>	<u>Software</u>
		<u>Scenic Nursing and Rehabilitation Center, LLC</u>	<u>Herculaneum</u>	<u>White Hall Property C</u>	<u>White Hall</u>	<u>Property Company</u>
		<u>Jefferson City Nursing & Rehabilitation Center, LLC</u>	<u>Jefferson City</u>	<u>3690 N. H. Associates,</u>	<u>Orchard Park</u>	<u>Clearing Account</u>
		<u>Riverside Nursing and Rehabilitation Center, LLC</u>	<u>Kansas City</u>	<u>Health Care Risk Gro</u>	<u>Orchard Park</u>	<u>Insurance</u>
		<u>Douglasville Nursing & Rehabilitation Center, LLC</u>	<u>Douglasville</u>	<u>Aurora Cares, LLC d/</u>	<u>Orchard Park</u>	<u>Support Office</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	21	<u>Wireless Access Points License Fee</u>	<u>\$ 2,464</u>	<u>Raimax Healthcare Solutions Group, LLC</u>	<u>0.00%</u>	<u>\$ (1,395)</u>	1
2	V	15	<u>Wireless Access Points License Fee</u>	<u>605</u>	<u>Raimax Healthcare Solutions Group, LLC</u>	<u>0.00%</u>	<u>(605)</u>	2
3	V	15	<u>Patient Care Software</u>	<u>3,600</u>	<u>Raimax Healthcare Solutions Group, LLC</u>	<u>0.00%</u>	<u>(4,491)</u>	3
4	V	10	<u>Pharmacy Consulting Services</u>	<u>25,704</u>	<u>Tara Pharmacy SE, LLC</u>	<u>0.00%</u>	<u>1,953</u>	4
5	V	43	<u>FluVac/Prescription Drug-Residents</u>	<u>217,914</u>	<u>Tara Pharmacy SE, LLC</u>	<u>0.00%</u>	<u>(74,594)</u>	5
6	V	22	<u>Hep B & TB Vaccines for Employees</u>	<u>2,414</u>	<u>Tara Pharmacy SE, LLC</u>	<u>0.00%</u>	<u>95</u>	6
7	V	15	<u>Misc. Sales & Delivery Charges</u>	<u>1,740</u>	<u>Tara Pharmacy SE, LLC</u>	<u>0.00%</u>	<u>(1,740)</u>	7
8	V	10a	<u>Physical Therapy Fees</u>	<u>469,229</u>	<u>Tara Therapy, LLC</u>	<u>0.00%</u>	<u>13,402</u>	8
9	V	10a	<u>Occupational Therapy Fees</u>	<u>374,568</u>	<u>Tara Therapy, LLC</u>	<u>0.00%</u>	<u>(19,932)</u>	9
10	V	10a	<u>Speech Therapy Fees</u>	<u>134,722</u>	<u>Tara Therapy, LLC</u>	<u>0.00%</u>	<u>33,128</u>	10
11	V	17	<u>Administrative Services Costs</u>	<u>387,132</u>	<u>Aurora Cares, LLC d/b/a Tara Cares</u>	<u>0.00%</u>	<u>(131,950)</u>	11
12	V							12
13	V							13
14	Total		<u>\$ 1,620,092</u>			<u>\$ 1,433,963</u>	<u>\$ * (186,129)</u>	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	\$ 820,800	White Hall Property Company, LLC	0.00%	\$	\$(820,800)
16	V	30 Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	35,605	35,605
17	V	30 Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	11,061	11,061
18	V	30 Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	5,926	5,926
19	V	27 Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	8,831	8,831
20	V	32 Interest -Capital /LongTerm		White Hall Property Company, LLC	0.00%	210,174	210,174
21	V	32 Interest - Working CapSwap		White Hall Property Company, LLC	0.00%	129,383	129,383
22	V	1 Dietary Services	13,870	Scenic Nursing and Rehabilitation Center, LLC	0.00%	13,870	
23	V	10 Nursing Services	225	Scenic Nursing and Rehabilitation Center, LLC	0.00%	225	
24	V	10 Nursing Services	39,442	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	39,442	
25	V	10 MDS Services	251	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	251	
26	V	10 Nursing Services	860	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	860	
27	V	12 Social Services	306	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	306	
28	V	21 Clerical and General Office	87	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	87	
29	V	6 Maintenance Services	204	Granite Nursing and Rehabilitation Center, LLC	0.00%	204	
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 876,045			\$ 456,225	\$ * (419,820)

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

Facility Name & ID Number

White Hall Nsg & Rehab Ctr

0046896

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

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		Owner	0	0	0.00		\$ 0	17	1
2	D & N, LLC	Owner		Owner	0	0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO		CFO & Co***		0.81	2.03	Fin/ Adm. of TC	6,171	17	3
4		for Tara Cares		for Tara Cares							4
5	Norbert A. Bennett	CEO for Tara Cares		CEO for T***		0.81	2.03	Fin/ Adm. of TC	6,171	17	5
6											6
7	Suzette Wilson	Vice President		Vice Presid***		0.81	2.03	VP of TC	5,512	17	7
8											8
9											9
10	*** Compensation paid only through Support Office and allocated share reported in column 7.										10
11											11
12											12
13								TOTAL	\$ 17,854		13

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr

0046896 Report Period Beginning: 01/01/2016

Ending: 2/31/2016

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	Total Costs	40	\$ 327,613	\$ 248,771	7,830,099	\$ 6,518	1	
2	5	Administrative Services Costs	Days	36	39,084	0	39,674	986	2	
3	6	Administrative Services Costs	Days	36	73,458	0	39,674	1,852	3	
4	10	Administrative Services Costs	Total Costs	40	2,792,167	2,199,184	7,830,099	55,526	4	
5	17	Administrative Services Costs	Days	36	5,935,931	5,935,931	39,674	149,660	5	
6	19	Administrative Services Costs	Days	36	10,996	0	39,674	277	6	
7	20	Administrative Services Costs	Days	36	13,064	0	39,674	329	7	
8	21	Administrative Services Costs	Days	36	280,112	0	39,674	7,064	8	
9	22	Administrative Services Costs	Days	36	874,230	0	39,674	22,042	9	
10	24	Administrative Services Costs	Days	36	142,490	0	39,674	3,593	10	
11	26	Administrative Services Costs	Days	36	5,764	0	39,674	145	11	
12	27	Administrative Services Costs	Days	36	92,390	0	39,674	2,330	12	
13	30	Administrative Services Costs	Days	36	83,854	0	39,674	2,115	13	
14	31	Administrative Services Costs	Days	36	10,324	0	39,674	260	14	
15	33	Administrative Services Costs	Days	36	30,404	0	39,674	767	15	
16	34	Administrative Services Costs	Days	36	66,534	0	39,674	1,677	16	
17	35	Administrative Services Costs	Days	36	1,606	0	39,674	41	17	
18									18	
19									19	
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting facility. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.								22
23									23	
24									24	
25	TOTALS				\$ 10,780,021	\$ 8,383,886		\$ 255,182	25	

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Niagara Bank			Land and Building	\$27,885.00	2/28/14	\$ 6,368,179	\$ 5,773,085	2/28/34	LIBOR PI	\$ 247,614	1								
2	First Niagara Bank			Land and Building	\$11,318.00	2/28/14	2,706,821	2,333,327	03/01/19	LIBOR PLUS	91,943	2								
3												3								
4												4								
5												5								
Working Capital																				
6	None											6								
7												7								
8												8								
9	TOTAL Facility Related				\$39,203.00		\$ 9,075,000	\$ 8,106,412			\$ 339,557	9								
B. Non-Facility Related*																				
10	None											10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 9,075,000	\$ 8,106,412			\$ 339,557	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2015 report.	\$	87,400		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.)	\$	75,672		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	(11,728)		3
4.	Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	160,760		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	\$	149,032		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	<u>75,736</u>	8	
		2012	<u>81,020</u>	9	
		2013	<u>79,245</u>	10	
		2014	<u>75,398</u>	11	
		2015	<u>75,672</u>	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nsg & 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 2015 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 2015.

(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>75,672.48</u>	\$ <u>75,672.48</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>75,672.48</u></u>	\$ <u><u>75,672.48</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,655 B. General Construction Type: Exterior 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).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 63,995 2. Number of Years Over Which it is Being Amortized: 5 years (60 months)
 3. Current Period Amortization: Included in Schedule VII B Ln 1-8 4. Dates Incurred: Various and on the books of related entities

Nature of Costs: Inc. Capitalized Pre-Opening Salaries, Benefits&OtherCostsIncurred2009&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	<u>209,829</u>		<u>\$ 19,707</u>	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		
Bed* 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	\$	\$ 32,591	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Alumalite Sign	2005	797		10			797		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	54	10	54		1,080		11
12	Sign Pillars w/ Lighting	2006	8,975	449	10	449		8,975		12
13	Window Treatment	2006	13,663	683	10	683		13,663		13
14	Shower Room Renovations	2006	46,015	3,834	12	3,834		40,263		14
15	Measure & Install Blinds in Facility	2006	10,998		5			10,998		15
16	Handrail and Background Staining	2006	14,880	1,240	12	1,240		13,020		16
17	Electrical Wiring (lighting & smoke detectors)	2006	23,000	1,917	12	1,917		20,125		17
18	Sprinkler System Repairs, capitalized for Medicaid	2006	3,194		3			3,194		18
19	Installation of Data Outlet Recepticles for Medicaid	2007	4,160		3			4,160		19
20	Dry Wall - Entire Building	2007	10,329	1,033	10	1,033		9,813		20
21	3 Electric Water Heaters	2007	2,534	253	10	253		2,407		21
22	Phone System	2007	10,021	1,002	10	1,002		8,517		22
23	Dish Machine	2007	4,000	400	10	400		3,400		23
24	Smoke Detectors	2008	3,125	312	10	312		2,656		24
25	Window replacement (windows, sills, trim)	2009	40,527	4,503	9	4,503		33,773		25
26	Nurse Station	2009	56,951	6,328	9	6,328		47,459		26
27	Tile Floor	2009	13,887	1,543	9	1,543		11,572		27
28	A/C Roof Unit Repair - capitalized for Medicaid	2009	2,948		3			2,948		28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	A/C Units (4)	2010	\$ 2,099	\$	5	\$	\$	2,099	37
38	A/C Units (3)	2010	1,626	203	8	203		1,321	38
39	Walk-In Freezer	2010	12,075	1,509	8	1,509		9,811	39
40	RepairsFromLightningStrike-capMedREDUCED ON AUDIT	2010	8,790		3			8,790	40
41	Water Softener System	2011	4,233	605	7	605		3,326	41
42	A/C Unit (5)	2011	2,688	269	5	269		2,688	42
43	Window Replacement	2011	47,741	6,820	7	6,820		37,511	43
44	Parking Lot Repairs capitalized for Medicaid	2011	2,600		3			2,600	44
45	A/C Units (4)	2012	2,372	474	5	474		2,134	45
46	Air Curtain	2012	721	48	15	48		216	46
47	Built-in AC Units (2)	2012	1,186	237	5	237		1,067	47
48	5-Ton AC Unit	2013	3,929	262	15	262		917	48
49	2 Built in AC Units	2013	1,258	252	5	252		881	49
50	Cabling - Wireless Upgrade	2013	3,539	177	20	177		619	50
51	Replaced Floor Tile in Dining Room and North Lounge	2013	17,016	1,702	10	1,702		5,956	51
52									52
53	AC Units - Built in (2)	2013	1,258	252	5	252		881	53
54	Flooring for Behavior Memory Unit	2014	29,355	2,935	10	2,935		7,339	54
55	A/C Unit 8.5 Ton Rooftop	2014	9,837	984	10	984		2,459	55
56	AC Units - Built in (18)	2014	12,680	2,536	5	2,536		6,340	56
57	AC Units - Built in (4)	2014	2,593	519	5	519		1,297	57
58	Smoker's Gazebo (1)	2014	2,693	269	10	269		673	58
59	18 Bed / Therapy Expansion - IDPH # L3619	2015	3,760,340	150,414	25	150,414		225,620	59
60	Replace 1,000 sq feet of asphalt pavement- capitalized for Medicaid	2015	3,981	498	8	498		746	60
61	Labor and Materials to rebuild concrete pad for dumpster - Cap fo	2016	2,975	99	15	99		99	61
62									62
63	Note: See additional building improvements made by former		626,406	22,707		22,707		570,661	63
64	property owner Healthcare REIT, Inc. on supplemental								64
65	schedule included as page 24 of the cost report.								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,074,369	\$ 223,248		\$ 223,248	\$	\$ 1,169,732	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	\$ 458,268	\$ 74,235	\$ 74,235	\$	Various	\$ 182,017	71
72	Current Year Purchases	16,763	1,767	1,767		Various	1,767	72
73	Fully Depreciated Assets	174,944	1,645	1,645		Various	174,947	73
74								74
75	TOTALS	\$ 649,975	\$ 77,647	\$ 77,647	\$		\$ 358,731	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Long Term Care	2009 Ford E250 Extended	2009	\$ 36,675	\$	\$	\$	5	\$ 36,675	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			\$ 36,675	\$	\$	\$		\$ 36,675	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)	\$ 5,780,726	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,895	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,895	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)	\$ 1,565,138	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	None	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	None	\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr

0046896

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

**

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 41,516

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. /2017 \$ _____

13. /2018 \$ _____

14. /2019 \$ _____

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER CNA <u>88</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input checked="" type="checkbox"/> HOURS PER CNA <u>48</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ 916	\$	\$ 916
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	\$	\$ 916	\$	\$ 916
10 SUM OF line 9, col. 1 and 2 (e)	\$	916		

C. CONTRACTUAL INCOME

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

\$ 0

D. NUMBER OF CNAs TRAINED

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

- (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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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.

Facility Name & ID Number White Hall Nsg & Rehab Ctr
 XV. BALANCE SHEET - Unrestricted Operating Fund.

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

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,314	\$ 1
2	Cash-Patient Deposits	39,770	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,867,041	3
4	Supply Inventory (priced at cost)	5,983	4
5	Short-Term Investments		5
6	Prepaid Insurance	5,082	6
7	Other Prepaid Expenses	10,173	7
8	Accounts Receivable (owners or related parties)	(323,713)	8
9	Other(specify): Non Resident A/R (see TB)	65,077	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,690,727	\$ 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 Cos	3,833,611	15
16	Equipment, at Historical Cost	381,445	16
17	Accumulated Depreciation (book methods)	(402,360)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	(3,062)	21
22	Other Long-Term Assets (specify):	1,758	22
23	Other(specify): Deposits Long Term		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,811,392	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,502,119	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 96,761	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	43,636	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	293,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,188	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,760	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	Employee Benefits Payable	37,953	36
37	Accrued Expenses	290,897	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 968,997	\$ 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)	\$ 968,997	\$ 46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,533,122	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,502,119	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,495,457	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,495,457	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(302,909)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	625,374	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(284,800)	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)	\$ 37,665	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)	\$ 4,533,122	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,295,548	1
2	Discounts and Allowances for all Levels	718,813	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,014,361	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	196,454	5
6	Therapy	610,900	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 807,354	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	2,945	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,685	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,472	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,102	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	73,314	28
28a	Purchase Discounts & Misc Revenue	7,191	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 80,505	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,914,370	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,035,346	31
32	Health Care	3,609,546	32
33	General Administration	1,798,952	33
B. Capital Expense			
34	Ownership	1,230,090	34
C. Ancillary Expense			
35	Special Cost Centers	263,336	35
36	Provider Participation Fee	280,009	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,217,279	40
41	Income before Income Taxes (line 30 minus line 40)**	(302,909)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (302,909)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,382,682	44
45	Private Pay - Net Inpatient Revenue	1,290,275	45
46	Medicare - Net Inpatient Revenue	2,322,404	46
47	Other-(specify) <u>Hospice</u>	19,000	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,014,361	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 Nsg & Rehab Ctr

0046896

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

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	1,992	2,080	\$ 68,291	\$ 32.83	1
2	Assistant Director of Nursing	984	1,033	23,369	22.62	2
3	Registered Nurses	8,625	9,660	252,377	26.13	3
4	Licensed Practical Nurses	31,862	34,618	743,270	21.47	4
5	CNAs & Orderlies	78,673	85,934	971,217	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,897	2,121	32,447	15.30	9
10	Activity Assistants	3,815	4,010	38,327	9.56	10
11	Social Service Workers	5,556	6,101	86,650	14.20	11
12	Dietician					12
13	Food Service Supervisor	1,797	1,966	28,296	14.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,233	5,721	52,130	9.11	15
16	Dishwashers	15,575	17,355	157,004	9.05	16
17	Maintenance Workers	3,667	4,021	54,374	13.52	17
18	Housekeepers	14,782	16,395	161,819	9.87	18
19	Laundry	6,257	6,753	62,335	9.23	19
20	Administrator	1,888	2,291	77,225	33.71	20
21	Assistant Administrator					21
22	Other Administrative	5,442	6,325	142,254	22.49	22
23	Office Manager	1,561	1,872	37,455	20.01	23
24	Clerical	2,070	2,176	24,683	11.34	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	3,448	3,683	50,218	13.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Central Supply</u>	96	96	881	9.18	33
34	TOTAL (lines 1 - 33)	195,220	214,211	\$ 3,064,622 *	\$ 14.31	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		1-3	35	
36	Medical Director	277	16,068	9-3	36
37	Medical Records Consultant	16	560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$18/bed/month	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	32	1,976	11-3	44
45	Social Service Consultant	32	1,989	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	357	\$ 46,297		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	117	4,335	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	117	\$ 4,335		53

Facility Name & ID Number White Hall Nsg & Rehab Ctr
 XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lori McKinnon	Administrator	0	\$ 76,675	Workers' Compensation Insurance	\$ 78,441	IDPH License Fee	\$ 1,990	
Christine Warcup	Administrator	0	550	Unemployment Compensation Insurance	47,076	Advertising: Employee Recruitment	7,256	
Billye Titus	Administrator Asst	0	66,580	FICA Taxes	230,322	Health Care Worker Background Check	1,002	
Melissa Eschbach, Leah Henson	Bus. Office Mgr	0	37,455	Employee Health Insurance	96,029	(Indicate # of checks performed 22)		
Nancy Willenburg	HR/Payroll	0	36,506	Employee Meals		Patient Background Checks	129 1,290	
Scott Phares, Christopher Cox	Admiss Director/Asst	0	39,169	Illinois Municipal Retirement Fund (IMRF)*		Facility Advertising	30,676	
L.Henson,K. Schutz, C. Butler	Bus. Office Ast	0	24,682	Worker Compensation Safety Rec. Program	300	IL Health Care Association/Chamber/Econ I	8,004	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 281,617	Employee Benefits - Other	31,037	Non-allowHealthCareAssn/ChamberC	(3,178)	
(List each licensed administrator separately.)				Employee Benefits - S Term Disability/Life	495	Admin License Renew	150	
B. Administrative - Other				Employee Benefits - Hepatitis B Vaccination	496	Citrix License Renew/Fingerprinting/Facility	2,892	
Description			Amount	Employee Benefits- Life Insurance (ER)	1,405	Less: Public Relations Expense	()	
Tara Cares Administrative Service Fee			\$ 387,132	Employee Benefits - Exchange,Tuition,Dental	5,737	Non-allowable advertising	(30,676)	
				Employee Benefits - H.S.A. (ER)	4,560	Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 495,898	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,406	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 387,132	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services			Amount	None in allowable cost		\$	Out-of-State Travel	\$
Vendor/Payee	Type			(Column 8) of Schedule V				
Freed, Maxick & Battaglia	Accounting Fees		\$ 2,518					
Freed, Maxick & Battaglia	Tax Fees		2,438				In-State Travel	25,064
Various Legal Fees - See attached detailed listing			40,513					
							Seminar Expense	500
TOTAL (agree to Schedule V, line 19, column 3)			\$ 45,469	TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	\$ 25,564

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number White Hall Nsg & Rehab Ctr# 0046896Report Period Beginning: 01/01/2016Ending: 12/31/2016

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 \$4,826 net of non-allowables
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 53,753 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 280,009
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes outpatient services 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 benefit on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,945
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No Personal Use
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	<u>Improvements Made by Health Care REIT (covered by rent at outset</u>										
10	<u>of Change of Ownership):</u>										
11											11
12			2005		65,173	3,259		3,259		37,474	12
13			2005		213,004					213,004	13
14			2005		30,608					30,608	14
15			2005		4,650	358		358		4,114	15
16			2005		1,983	153		153		1,754	16
17			2006		18,611					18,612	17
18			2006		1,820	91		91		1,820	18
19			2006		2,380	198		198		2,082	19
20			2006		3,825					3,825	20
21			2006		55,141					55,141	21
22			2006		3,600	180		180		3,600	22
23			2006		9,979	499		499		9,979	23
24			2006		169,310	14,109		14,109		148,146	24
25			2006		46,322	3,860		3,860		40,502	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Total (lines 9 thru 35)				626,406	22,707		22,707		570,661	36

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

See Page 12A, Line 70 for total

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