

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785 Report Period Beginning: 9/1/16 Ending: 8/31/17

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	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,412	10,249	1,101	20,762	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,412	10,249	1,101	20,762	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.26%

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

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

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 4/31/1969

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 70 and days of care provided 924

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/17 Fiscal Year: 8/31/17

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

Facility Name & ID Number Resthve Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/16 Ending: 8/31/17

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	268,675	19,394	7,088	295,157		295,157		295,157		1
2	Food Purchase		233,399		233,399		233,399	(2,911)	230,488		2
3	Housekeeping	200,246	28,130	384	228,760		228,760		228,760		3
4	Laundry		1,243	1,725	2,968		2,968		2,968		4
5	Heat and Other Utilities			157,418	157,418		157,418		157,418		5
6	Maintenance	76,968	10,634	18,645	106,247		106,247		106,247		6
7	Other (specify):*										7
8	TOTAL General Services	545,889	292,800	185,260	1,023,949		1,023,949	(2,911)	1,021,038		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,532,447	91,151	109,078	1,732,676		1,732,676	(2,830)	1,729,846		10
10a	Therapy										10a
11	Activities	112,153	7,657		119,810		119,810		119,810		11
12	Social Services	87,037	65	2,046	89,148		89,148		89,148		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,731,637	98,873	129,124	1,959,634		1,959,634	(2,830)	1,956,804		16
	C. General Administration										
17	Administrative	68,430		36,163	104,593		104,593		104,593		17
18	Directors Fees										18
19	Professional Services			51,457	51,457		51,457		51,457		19
20	Dues, Fees, Subscriptions & Promotions			33,405	33,405		33,405	(3,525)	29,880		20
21	Clerical & General Office Expenses	178,036	7,887	254,583	440,506		440,506	(20,388)	420,118		21
22	Employee Benefits & Payroll Taxes			435,516	435,516		435,516		435,516		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,161	16,161		16,161		16,161		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,968	47,968		47,968		47,968		26
27	Other (specify):* Marketing	48,865	9,903	56,544	115,312		115,312	(115,312)			27
28	TOTAL General Administration	295,331	17,790	931,797	1,244,918		1,244,918	(139,225)	1,105,693		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,572,857	409,463	1,246,181	4,228,501		4,228,501	(144,966)	4,083,535		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

Resthave Home Whiteside Cnty

#0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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			464,080	464,080		464,080		464,080			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			463,503	463,503		463,503	(236)	463,267			32
33	Real Estate Taxes			9,851	9,851		9,851		9,851			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			937,434	937,434		937,434	(236)	937,198			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			111,044	111,044		111,044		111,044			39
40	Barber and Beauty Shops			24,767	24,767		24,767	(6,343)	18,424			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,761	169,761		169,761		169,761			42
43	Other (specify):* Amortization			1,224	1,224		1,224		1,224			43
44	TOTAL Special Cost Centers			306,796	306,796		306,796	(6,343)	300,453			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,572,857	409,463	2,490,411	5,472,731		5,472,731	(151,545)	5,321,186			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	(2,713)	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	(236)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,594)	21		24
25	Fund Raising, Advertising and Promotional	(115,312)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A Attachment	(16,690)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (151,545)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (151,545)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Resthve Home Whiteside Cnty

ID# 0005785

Report Period Beginning: 9/1/16

Ending: 8/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IHCA Dues - AL	\$ (2,115)	20	1
2	Miscellaneous Income	(3,794)	21	2
3	IHCA Dues - Portion for Lobbying	(1,410)	20	3
4	Marketing travel	0	24	4
5	Medical Supplies Revenue - AL	(2,830)	10	5
6	Barbre and Beauty Revenue - AL	(6,343)	40	6
7	Misc. Operating Income - AL	0	21	7
8	Guest Meals - AL	(198)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,690)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,911)	0	0	0	0	0	0	0	0	0	0	(2,911)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,911)	0	(2,911)	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	(2,830)	0	0	0	0	0	0	0	0	0	0	(2,830)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,830)	0	(2,830)	16									
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,525)	0	0	0	0	0	0	0	0	0	0	(3,525)	20
21	Clerical & General Office Expenses	(20,388)	0	0	0	0	0	0	0	0	0	0	(20,388)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(115,312)	0	0	0	0	0	0	0	0	0	0	(115,312)	27
28	TOTAL General Administration	(139,225)	0	(139,225)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(144,966)	0	(144,966)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(236)	0	0	0	0	0	0	0	0	0	0	(236)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(236)	0	0	0	0	0	0	0	0	0	0	(236)	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	(6,343)	0	0	0	0	0	0	0	0	0	0	(6,343)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(6,343)	0	0	0	0	0	0	0	0	0	0	(6,343)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(151,545)	0	0	0	0	0	0	0	0	0	0	(151,545)	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
N/A						

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

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

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/16 Ending: 8/31/17

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/16 Ending: 8/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	Triumph		X	LOC		8/21/16	\$ 40,000	\$ 624,500	8/21/2017	5.2500	\$ 27,658	1						
2	USDA		X	Association - organization		5/18/16	400,000	393,886	5/18/2055	3.5000	13,880	2						
3	USDA		X	Association - organization		5/18/16	7,020,000	7,020,000	5/18/2055	3.5000	194,513	3						
4												4						
5												5						
Working Capital																		
6	Triumph		X	Fund expansion project		9/21/16	4,680,000	4,613,571	9/21/2055	5.2300	221,193	6						
7	City of Morrison		X	Revolving Fund		9/25/13	300,000	195,352	9/1/2023	3.0000	6,259	7						
8												8						
9	TOTAL Facility Related						\$ 12,440,000	\$ 12,847,309			\$ 463,503	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 12,440,000	\$ 12,847,309			\$ 463,503	15						

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

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

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resthave Home Whiteside Cnty COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT Deb Freeland

TELEPHONE 317-574-9100 FAX #: 317-574-9707

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>09-17-352-015</u>	<u>Assisted Living Parcel</u>	\$ <u>35,731.00</u>	\$ _____
2.	<u>09-17-352-016</u>	<u>NH Building Parcel</u>	\$ <u>47,405.00</u>	\$ <u>47,405.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>83,136.00</u></u>	\$ <u><u>47,405.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 71,809 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (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).

37 Assisted Living Units

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Rows include Facility Location, Creek Street Property, and TOTALS.

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	25			1961	\$ 140,758	\$	30	\$	\$	\$
5	49			1969	326,818		15-33			
6										
7										
8										
	Improvement Type**									
9		LAUNDRY REMODELING		1974	6,242		20			
10		GARAGE		1976	2,235		20			
11		ROCK GARAGE DRIVE		1976	85		10			
12		GARAGE WIRING & DOOR CLOSURE		1980	1,021		10 TO 15			
13		SEAL BACK DRIVEWAY		1980	660		5			
14		FIREPROOF I-BEAM		1981	1,039		10			
15		PATIENT REC ROOM		1982	127,130		30			
16		LANDSCAPE ALONG DRIVE		1982	400		5			
17		CEILINGS		1983	13,650		15			
18		TREES, SHRUBS		1983	466		10			
19		PORCH & ACCESS		1984	7,954		10 TO 20			
20		SOUTH PORCH, ELEC DOOR		1984	394		10			
21		CARPET ALL PORCHES		1984	1,400		10			
22		TREES, SHRUBS		1984	2,081		10			
23		ASPHALT SEAL PARKING LOT		1984	10,950		10			
24		BASEMENT REPAIR		1985	2,947		10			
25		SHRUBS, FLOWERS		1985	933		10			
26		ACTIVATORS/RADIATORS		1986	585		10			
27		HANDRAIL, RAMP, CARPET		1986	1,137		10			
28		HEAT CONTROLS VALVES		1986	851		10			
29		FLOWERS, WOOD CHIPS		1986	125		10			
30		GAZEBO		1987	1,575		10			
31		AIR CONDITIONING		1987	1,048		10			
32		REROOFING/PORCH REPAIR		1988	14,500		10			
33		DUCTS FOR KITCHEN EQUIPMENT		1989	1,910		20			
34		BRICK FOR BUILDING		1989	8,500		25			
35		OVERHANG ON BUILDING		1989	3,810		15			
36		CARPET		1993	581		10			

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	NURSING ROOF REPAIR	1993	\$ 4,840	\$	15	\$	\$	\$	37
38	BUILDING ADDITION	1993	203,556		10 TO 30				38
39	CARPET ALL PORCHES	1996	352		10				39
40	FOLDING DOORS	1996	2,090		15				40
41	SCREEN DOORS	1996	540		15				41
42	FOLDING DOORS	1996	6,688		15				42
43	DOORS	1997	828		15				43
44	SPRINKLER SYSTEM	1997	8,432		30				44
45	FLOORING	1998	991		7				45
46	CONCRETE SIDEWALK	1998	1,760		10				46
47	ROCK FOR SIDEWALK	1999	6,884		10				47
48	ROCK, FRONT OF BUILDING	1999	1,770		10				48
49	LIGHT POLES - PARKING LOT	1999	6,640		10				49
50	BLACKTOP	1999	9,075		10				50
51	BLACKTOP	1999	2,925		10				51
52	DOOR ALARM SYSTEM	2001	25,906		10				52
53	SHRUBBERY	2001	1,443		10				53
54	CANOPY	2001	33,843		10				54
55	CANOPY AND PLANTERS	2001	6,530		10				55
56	TREE SHRUBS	2002	335		10				56
57	SHINGLES	2003	15,500		10				57
58	ROOFING LABOR	2003	15,000		10				58
59	ALARM FOR NEW DOOR	2003	3,417		10				59
60	FINAL ROOF PAYMENT	2003	15,274		10				60
61	DOOR LOCKS	2004	8,234		5				61
62	GARAGE	2004	36,457		20				62
63	BASEMENT WATERPROOFING - DRAIN	2010	19,280		15				63
64	BATHROOM STOOLS	2011	2,346		10				64
65	BURY DOWN SPOUTS AND REPAIR RISERS	2014	7,436		10				65
66	GENERATOR	2015	302,535		10				66
67	LIFT STATION	2015	65,000		10				67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,497,692	\$		\$	\$	\$	70

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

Facility Name & ID Number Resthove Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	
1	Totals from Page 12A, Carried Forward		\$ 1,497,692	\$		\$	\$	\$	1
2	EXCAVATION - FISCHER EXCAVATING	2015	333,979		20				2
3	ASPHALT PAVING - FISCHER EXCAVATING	2015	130,367		20				3
4	LANDSCAPING - TWIN OAKS	2015	39,350		20				4
5	CONCRETE - NORTHWEST COMMERCIAL	2015	423,977		20				5
6	MASONRY - DIAMOND MASONRY	2015	62,600		20				6
7	GENERAL TRADES - LAMP INCORPORATED	2015	1,976,033		20				7
8	ROOFING - CPR ROOFING INC.	2015	267,184		20				8
9	DRYWALL - NIWC	2015	695,874		20				9
10	FLOORING - ROCKFORD CARPETLAND	2015	323,822		20				10
11	PAINTING - ALL TECH DECORATING	2015	103,080		20				11
12	PLUMBING - MOST PLUMBING	2015	795,841		20				12
13	FIRE PROTECTION - TRISTATE AUTOMATIC SPRINKLER	2015	284,644		20				13
14	HVAC - HEAT CO MECHANICAL	2015	988,190		20				14
15	ELECTRICAL - COMPLETE ELECTRIC	2015	961,263		20				15
16	Phase 3 Building	2015	5,059,576		20				16
17	Capitalized interest	2015	777,503		20				17
18	Phase 2 - Building improvement	2015	110,030		20				18
19	Soft Water Line to Mixing Valve	2016	2,352		15				19
20	Re-wire basement mechanical room	2016	3,600		39				20
21	Med Records & Dining Addition, walls, flooring, paint	2016	12,095		39				21
22	DINING ROOM ACCOUSTICS	2017	8,802		10				22
23	PUMP MOTOR	2017	10,344		10				23
24									24
25									25
26									26
27									27
28									28
29									29
30	Total Buildings and Improvement Depreciation			357,149		357,149		1,713,898	30
31									31
32	Adjustment to Assisted Living		(1,386,204)						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,481,994	\$ 357,149		\$ 357,149	\$	\$ 1,713,898	34

**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	\$ 841,320	\$	\$	\$	Var	\$	71
72	Current Year Purchases	31,600				Var		72
73	Fully Depreciated Assets	807,620				Var	807,620	73
74	Total Equipment Depreciation		101,332	101,332				74
75	TOTALS	\$ 1,680,540	\$ 101,332	\$ 101,332	\$		\$ 807,620	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	Maintenance	2012 Ford Van S2E	2012	\$ 48,130	\$	\$	\$	5	\$	76
77	Maintenance	2001 Dodge Ram 1500	2014	5,500				5		77
78	Maintenance	Snow Plow Blade	2014	4,879	5,599	5,599		10	52,772	78
79										79
80	TOTALS			\$ 58,509	\$ 5,599	\$ 5,599	\$		\$ 52,772	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)	\$ 15,232,520	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 464,080	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 464,080	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)	\$ 2,574,290	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	Bldg & Bldg Improvement 2015	\$ 1,386,204	\$	\$	86
87	Assisted Living - Equipment 2015	242,563	11,463		87
88					88
89					89
90					90
91	TOTALS	\$ 1,628,767	\$ 11,463	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. 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

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. _____ /2018 \$ _____
 13. _____ /2019 \$ _____
 14. _____ /2020 \$ _____

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: \$ 0 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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	\$ 0		\$ 0	\$ 0		\$	1
2	Licensed Speech and Language Development Therapist		hrs			0				2
3	Licensed Recreational Therapist		hrs			0				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			0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____						0			12
13	Other (specify): _____						0			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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 27,266	\$	1
2	Cash-Patient Deposits	(221)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	735,159		3
4	Supply Inventory (priced at)	11,629		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,490		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(118,002)		8
9	Other(specify):	118,002		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 798,323	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	374,700		12
13	Land	11,477		13
14	Buildings, at Historical Cost	14,440,885		14
15	Leasehold Improvements, at Historical Cost	96,369		15
16	Equipment, at Historical Cost	1,341,457		16
17	Accumulated Depreciation (book methods)	(2,419,954)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Fees</u>	46,627		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,891,561	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,689,884	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 231,229	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,675		30
31	Accrued Taxes Payable (excluding real estate taxes)	69,666		31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,159		32
33	Accrued Interest Payable	48,423		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 755,152	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	12,847,309		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)	\$ 12,847,309	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,602,461	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,087,423	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,689,884	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,652,074	1
2	Restatements (describe):	(104,962)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,547,112	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(459,689)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (459,689)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,087,423	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning: 9/1/16

Ending:

8/31/17

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	\$ 4,327,206	1
2	Discounts and Allowances for all Levels	(949,777)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,377,429	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	462,139	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 462,139	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,949	13
14	Non-Patient Meals	2,713	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,522	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	170	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 70,354	23
D. Non-Operating Revenue			
24	Contributions	18,745	24
25	Interest and Other Investment Income***	34,665	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,410	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Assisted Living</u>	1,045,916	28
28a	<u>Miscellaneous</u>	3,794	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,049,710	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,013,042	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,023,949	31
32	Health Care	1,959,634	32
33	General Administration	1,244,918	33
B. Capital Expense			
34	Ownership	937,434	34
C. Ancillary Expense			
35	Special Cost Centers	137,035	35
36	Provider Participation Fee	169,761	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,472,731	40
41	Income before Income Taxes (line 30 minus line 40)**	(459,689)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (459,689)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,310,262	44
45	Private Pay - Net Inpatient Revenue	2,008,886	45
46	Medicare - Net Inpatient Revenue	(115,954)	46
47	Other-(specify) <u>Insurance/Hospice</u>	174,235	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,377,429	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending:

8/31/17

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	2,083	2,163	\$ 128,853	\$ 59.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,708	8,175	285,933	34.98	3
4	Licensed Practical Nurses	17,731	19,436	367,041	18.88	4
5	CNAs & Orderlies	65,851	70,131	710,538	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,805	2,080	39,891	19.18	9
10	Activity Assistants	8,342	8,879	72,262	8.14	10
11	Social Service Workers	3,558	3,813	87,037	22.83	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,080	35,420	17.03	13
14	Head Cook	7,184	7,920	91,081	11.50	14
15	Cook Helpers/Assistants	14,576	15,819	142,174	8.99	15
16	Dishwashers					16
17	Maintenance Workers	5,059	5,464	76,968	14.09	17
18	Housekeepers	18,338	19,572	200,246	10.23	18
19	Laundry					19
20	Administrator	1,904	2,357	68,430	29.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,850	2,080	84,547	40.65	23
24	Clerical	5,572	5,992	93,489	15.60	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	1,525	1,735	17,171	9.90	31
32	Other Health Care(specify)	1,952	2,080	22,911	11.01	32
33	Other(specify)	1,870	2,080	48,865	23.49	33
34	TOTAL (lines 1 - 33)	168,778	181,856	\$ 2,572,857 *	\$ 14.15	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	107	\$ 8,175	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	18	1,833	10-3	38
39	Pharmacist Consultant	143	4,280	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				44
45	Social Service Consultant	16	1,086	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	\$ 15,374		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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		
Tami Tegeler	Administrator	0	\$ 68,430	Workers' Compensation Insurance	\$ 46,706	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	199,573	Health Care Worker Background Check			
				Employee Health Insurance	175,447	(Indicate # of checks performed 28)	850		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Memberships	24,129		
				401k	5,893	Taxes and licenses	2,740		
				Employee Physicals	5,711	IHCA dues	5,686		
				Employee Life Insurance	2,186				
						Less IHCA AL and lobbying	(3,525)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,430	TOTAL (agree to Schedule V, line 22, col.8)		\$ 29,880			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	2,837	
							Seminar Expense	13,324	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 16,161
C. Professional Services									
Vendor/Payee	Type		Amount						
Duane Morris LLP	Legal		\$ 15,971						
Nelson, Kilgus, Richey & Buckwalter	Legal		1,188						
Steven Pearlman & Associates	Legal		518						
CliftonLarsonAllen	Accounting		33,780						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 51,457						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Resthave Home Whiteside Cnty

0005785

Report Period Beginning:

9/1/16

Ending: 8/31/17

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 \$4,962
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,988 Line 10
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ _____
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,713
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen
- (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