FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0046896

Facility Name: White Hall Nursing and Rehabilitation Center, LLC

Address: 620 W Bridgeport Street (Number) White Hall (City) 62092 (Zip Code)

County: Greene

Telephone Number: (217)374-2144 **Fax #** (217)374-6714

HFS ID Number:

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary F. Eye **Telephone Number:** (716) 662-4955 ext 392
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 4/30/12 (Date)
(Type or Print Name) Gary F. Eye
(Title) Senior VP of Finance of Tara Cares

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,240	3,703	4,498	29,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,240	3,703	4,498	29,441	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.78%

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)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date January 1, 2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 4,223

Medicare Intermediary Wisconsin Physicians Insurance Corp. (WPS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 1/1 to 12/31/11 Fiscal Year: 1/1 to 12/31/11

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Cente # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	147,681	16,162	20,816	184,659		184,659	(394)	184,265			1
2	Food Purchase		175,117		175,117		175,117	(2,498)	172,619			2
3	Housekeeping	126,930	16,975	2,395	146,300		146,300		146,300			3
4	Laundry	47,015	11,677		58,692		58,692		58,692			4
5	Heat and Other Utilities			95,182	95,182		95,182	(480)	94,702			5
6	Maintenance	30,313	16,458	20,299	67,070		67,070	(2,624)	64,446			6
7	Other (specify):* see trial balance			16,720	16,720		16,720		16,720			7
8	TOTAL General Services	351,939	236,389	155,412	743,740		743,740	(5,996)	737,744			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,329,993	134,906	328,360	1,793,259		1,793,259	(7,564)	1,785,695			10
10a	Therapy		2,021	703,717	705,738		705,738	5,968	711,706			10a
11	Activities	40,205	1,355	2,089	43,649		43,649	(3)	43,646			11
12	Social Services	31,325	771	1,643	33,739		33,739		33,739			12
13	CNA Training											13
14	Program Transportation			13,110	13,110		13,110		13,110			14
15	Other (specify):* see trial balance			21,928	21,928		21,928	(2,134)	19,794			15
16	TOTAL Health Care and Programs	1,401,523	139,053	1,086,447	2,627,023		2,627,023	(3,733)	2,623,290			16
	C. General Administration											
17	Administrative	177,360		248,496	425,856		425,856	(39,916)	385,940			17
18	Directors Fees											18
19	Professional Services			72,093	72,093		72,093	(3,092)	69,001			19
20	Dues, Fees, Subscriptions & Promotions			32,309	32,309		32,309	(9,151)	23,158			20
21	Clerical & General Office Expenses		44,701	27,465	72,166		72,166	(9,768)	62,398			21
22	Employee Benefits & Payroll Taxes			458,821	458,821		458,821	(1,717)	457,104			22
23	Inservice Training & Education											23
24	Travel and Seminar			46,703	46,703		46,703	116	46,819			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(42,423)	(42,423)		(42,423)	(2,600)	(45,023)			26
27	Other (specify):* see trial balance			82,250	82,250		82,250	(13,328)	68,922			27
28	TOTAL General Administration	177,360	44,701	925,714	1,147,775		1,147,775	(79,456)	1,068,319			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,930,822	420,143	2,167,573	4,518,538		4,518,538	(89,185)	4,429,353			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC #0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,095	41,095		41,095	39,764	80,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							4,989	4,989			32
33	Real Estate Taxes			78,136	78,136		78,136		78,136			33
34	Rent-Facility & Grounds			306,991	306,991		306,991	(126,078)	180,913			34
35	Rent-Equipment & Vehicles			29,703	29,703		29,703		29,703			35
36	Other (specify):*											36
37	TOTAL Ownership			455,925	455,925		455,925	(81,325)	374,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,800	1,800		1,800		1,800			39
40	Barber and Beauty Shops		76	552	628		628		628			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* see trial balance			207,220	207,220		207,220	(66,213)	141,007			43
44	TOTAL Special Cost Centers		76	274,725	274,801		274,801	(66,213)	208,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,930,822	420,219	2,898,223	5,249,264		5,249,264	(236,723)	5,012,541			45

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(17)	2		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,378)	2		4
5	Telephone, TV & Radio in Resident Rooms	(480)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,932)	32		10
11	Discounts, Allowances, Rebates & Refunds	(110)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	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				18
19	Entertainment				19
20	Contributions	(1,350)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(356)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,732)	27		24
25	Fund Raising, Advertising and Promotional	(9,234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,069)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (71,761)		$	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 Amount	2 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)	(164,962)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (164,962)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,723)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

White Hall Nursing and Rehabilitation Center, LLC

ID# 0046896

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove non-allowable Admiss-Other Supplies	$ (9,651)	21	1
2	Remove non-allowable EE Recognition Program	(1,037)	22	2
3	Remove non-allowable Visa Cost	(87)	24	3
4	Remove non-allowable Insurance Cost	(2,600)	26	4
5	Remove non-allowable Nrsg Admin-Purch Svcs	(1,384)	15	5
6	Remove non-allowable Admin-Other Purch Svcs	(1,858)	27	6
7	Allow NRS Admin - Lodging not accrued	203	24	7
8	Remove non-allowable Dental-Physician Fees	(118)	43	8
9	Remove non-allowable Psychiatric-Physician Fees	(3,000)	43	9
10	Remove non-allowable Outpatient Svcs-Consol Billing	(6,659)	43	10
11	Remove non-allowable BO-Tax Prep Fees	(2,568)	19	11
12	Remove non-allowable IV Prescription Drugs	(2,464)	43	12
13	Remove non-allowable Prior Year Costs	(11,016)	43	13
14	Allow Admin-Licenses & Permits not accrued	83	20	14
15	Remove Capitalized Repairs & Maintenance	(2,600)	6	15
16	Amort/Depreciate Repair/Maint Captl for Medicaid	4,749	30	16
17	Offset Day Care Revenue	(3)	11	17
18	Offset Day Care Revenue	(78)	34	18
19	Offset Misc. Revenue	(611)	10	19
20	Offset Misc. Revenue	(11)	10	20
21	Offset Misc. Revenue	(24)	6	21
22	Offset Misc. Revenue	(288)	10	22
23	Offset Misc. Revenue	(40)	10	23
24	Offset Misc. Revenue	(7)	21	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**	(41,069)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	0	(394)	0	0	0	0	0	0	0	0	0	(394)	1
2	Food Purchase	(2,498)	0	0	0	0	0	0	0	0	0	0	(2,498)	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	(480)	0	0	0	0	0	0	0	0	0	0	(480)	5
6	Maintenance	(2,624)	0	0	0	0	0	0	0	0	0	0	(2,624)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,602)	(394)	0	0	0	0	0	0	0	0	0	(5,996)	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	(950)	(6,614)	0	0	0	0	0	0	0	0	0	(7,564)	10
10a	Therapy	0	5,968	0	0	0	0	0	0	0	0	0	5,968	10a
11	Activities	(3)	0	0	0	0	0	0	0	0	0	0	(3)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,384)	(750)	0	0	0	0	0	0	0	0	0	(2,134)	15
16	**TOTAL Health Care and Programs**	(2,337)	(1,396)	0	0	0	0	0	0	0	0	0	(3,733)	16
	C. General Administration													
17	Administrative	0	(39,916)	0	0	0	0	0	0	0	0	0	(39,916)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,924)	0	(168)	0	0	0	0	0	0	0	0	(3,092)	19
20	Fees, Subscriptions & Promotions	(9,151)	0	0	0	0	0	0	0	0	0	0	(9,151)	20
21	Clerical & General Office Expenses	(9,768)	0	0	0	0	0	0	0	0	0	0	(9,768)	21
22	Employee Benefits & Payroll Taxes	(1,037)	(680)	0	0	0	0	0	0	0	0	0	(1,717)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	116	0	0	0	0	0	0	0	0	0	0	116	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):*	(17,940)	0	4,612	0	0	0	0	0	0	0	0	(13,328)	27
28	**TOTAL General Administration**	(43,304)	(40,596)	4,444	0	0	0	0	0	0	0	0	(79,456)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,243)	(42,386)	4,444	0	0	0	0	0	0	0	0	(89,185)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	4,749	0	35,015	0	0	0	0	0	0	0	0	39,764	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,932)	0	6,921	0	0	0	0	0	0	0	0	4,989	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(78)	0	(126,000)	0	0	0	0	0	0	0	0	(126,078)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,739	0	(84,064)	0	0	0	0	0	0	0	0	(81,325)	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):*	(23,257)	(42,956)	0	0	0	0	0	0	0	0	0	(66,213)	43
44	**TOTAL Special Cost Centers**	(23,257)	(42,956)	0	0	0	0	0	0	0	0	0	(66,213)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(71,761)	(85,342)	(79,620)	0	0	0	0	0	0	0	0	(236,723)	45

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center, LLC	Granite City	Colonnades Property C	Granite City	Property Company
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Stearns Property Com	Granite City	Property Company
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Hardin Property Com	Hardin	Property Company
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	Herculaneum Property	Herculaneum	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	Jefferson City Propert	Jefferson City	Property Company
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Riverside Property Co	Kansas City	Property Company
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Terrace Square (Doug	Douglasville	Property Company

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 248,496	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 208,580	$ (39,916)	1
2	V	34	Sublease Building & Equip	180,991	Tara Midwest, LLC	0.00%	180,991		2
3	V	10	Pharmacy Consulting Services	25,704	Tara Pharmacy SE, LLC	0.00%	19,480	(6,224)	3
4	V	10	Medical Administration Records	7,854	Tara Pharmacy SE, LLC	0.00%	7,464	(390)	4
5	V	43	FluVac/Prescription Drug-Residents	162,016	Tara Pharmacy SE, LLC	0.00%	119,060	(42,956)	5
6	V	22	Flu & TB Vaccines for Employees	2,001	Tara Pharmacy SE, LLC	0.00%	1,321	(680)	6
7	V	10a	Physical Therapy Fees	301,369	Tara Therapy, LLC	0.00%	317,111	15,742	7
8	V	10a	Occupational Therapy Fees	283,338	Tara Therapy, LLC	0.00%	250,189	(33,149)	8
9	V	10a	Speech Therapy Fees	118,292	Tara Therapy, LLC	0.00%	141,667	23,375	9
10	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	2,850	(750)	10
11	V	1	Dietary Service	14,506	Sceinic Nursing and Rehabilitation Center, LLC	0.00%	14,212	(294)	11
12	V	1	Dietary Service	2,491	Stearns Nursing and Rehabilitation Center, LLC	0.00%	2,410	(81)	12
13	V	1	Dietary Service	318	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	299	(19)	13
14	Total			$ 1,350,976			$ 1,265,634	$ * (85,342)	14

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 126,000	White Hall Property Company, LLC	0.00%	$	$ (126,000)	15
16	V	30	Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	17,708	17,708	16
17	V	30	Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	14,344	14,344	17
18	V	30	Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	2,963	2,963	18
19	V	27	Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	4,612	4,612	19
20	V	32	Interest-Capital/Long-Term Debt		White Hall Property Company, LLC	0.00%	6,921	6,921	20
21	V	19	Nursing Service	3,015	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	2,847	(168)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,015			$ 49,395	$ * (79,620)	39

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

This page may also be used to list the Board of Directors for non-profit facilities. In the "Ownership %", enter "BOD".
IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1					Tara Pharmacy SE, LI	Birmingham	Pharmacy	1
2					Tara Therapy, LLC	Orchard Park	Therapy	2
3					Raimax Healthcare So	Orchard Park	Software	3
4					White Hall Property C	White Hall	Property Company	4
5								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number White Hall Nursing and Rehabilitation Cent # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3											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 White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Days	1,438,901	36	$ 238,080	$ 220,332	29,434	$ 4,870	1
2	5	Administrative Services Costs	Days	1,438,901	36	32,904	0	29,434	673	2
3	6	Administrative Services Costs	Days	1,438,901	36	59,825	1,412	29,434	1,224	3
4	10	Administrative Services Costs	Days	1,438,901	36	2,062,719	1,958,819	29,434	42,195	4
5	17	Administrative Services Costs	Days	1,438,901	36	5,701,164	5,701,164	29,434	116,623	5
6	19	Administrative Services Costs	Days	1,438,901	36	15,009	0	29,434	307	6
7	20	Administrative Services Costs	Days	1,438,901	36	14,140	0	29,434	289	7
8	21	Administrative Services Costs	Days	1,438,901	36	282,582	0	29,434	5,780	8
9	22	Administrative Services Costs	Days	1,438,901	36	1,301,441	0	29,434	26,622	9
10	24	Administrative Services Costs	Days	1,438,901	36	120,117	0	29,434	2,457	10
11	26	Administrative Services Costs	Days	1,438,901	36	6,145	0	29,434	126	11
12	27	Administrative Services Costs	Days	1,438,901	36	70,082	0	29,434	1,434	12
13	30	Administrative Services Costs	Days	1,438,901	36	159,143	0	29,434	3,255	13
14	31	Administrative Services Costs	Days	1,438,901	36	5,670	0	29,434	116	14
15	33	Administrative Services Costs	Days	1,438,901	36	27,413	0	29,434	561	15
16	34	Administrative Services Costs	Days	1,438,901	36	99,870	0	29,434	2,043	16
17	35	Administrative Services Costs	Days	1,438,901	36	236	0	29,434	5	17
18										18
19		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								19
20		Aurora Cares, LLC has no ownership interest and does not manage the reporting faciltiy. Therefore, Aurora Cares, LLC is not								20
21		considered a Home Office by CMS and as defined in 42CRF 421.404.								21
22										22
23										23
24										24
25	TOTALS					$ 10,196,540	$ 7,881,727		$ 208,580	25

Facility Name & ID Number White Hall Nursing and Rehabilitation Cente # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	M&T Bank		X	Purchase of Physical Plant	$1,100.00	6/22/11	$ 345,241	$ 345,241	7/22/13	0.0380	$ 6,921	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,100.00		$ 345,241	$ 345,241			$ 6,921	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 345,241	$ 345,241			$ 6,921	15

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

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC **#** 0046896 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,140	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.)		$ 73,796	2
3. Under or (over) accrual (line 2 minus line 1).		$ 656	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,480	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.		$ 78,136	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	66,416	8
2007	69,507	9
2008	70,837	10
2009	69,662	11
2010	73,796	12

The 2011 assessment was estimated to be a 5% increase over the 2010 assessment.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nursing and Rehabilitation Center, LLC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-53-34-400-002	620 W. Bridgeport	$ 73,795.54	$ 73,795.54
2.		3W JC 536	$	$
3.		34-12-12	$	$
4.		PT N MID PT E1/2 SE	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,795.54	$ 73,795.54

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 131,730
2. Number of Years Over Which it is Being Amortized: 5 yrs (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8
4. Dates Incurred: Various and on the books of the related entities.

Nature of Costs: Inc.capitalized pre-opening salaries, fringe benefits&other costs incurred prior 1/1/06.Costs allocated via related org cost&reported on Sch VII
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	209,829	2011	$ 19,707	1
2					2
3	TOTALS	209,829		$ 19,707	3

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		2011	1972	$ 237,024	$ 2,963	40	$ 2,963	$	$ 2,963	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	797	80	10	80		518	9
10	Generator Repairs, capitalized for Medicaid			2005	2,270		3			2,270	10
11	Auto Cad Design for Fire Alarm System			2006	1,080	108	10	108		594	11
12	Sign Pillars w/ Lighting			2006	8,975	898	10	898		4,937	12
13	Telewiring - Computer Outlets (2)			2006	1,473	36	40	36		202	13
14	Window Treatment			2006	13,663	1,366	10	1,366		7,515	14
15	Shower Room Renovations			2006	46,015	3,834	12	3,834		21,090	15
16	Measure & Install Blinds in Facility			2006	10,998	1,100	5	1,100		10,998	16
17	Handrail and Background Staining			2006	14,880	1,240	12	1,240		6,820	17
18	Electrical Wiring (lighting & smoke detectors)			2006	23,000	1,917	12	1,917		10,542	18
19	Concrete Sidewalk			2006	900	75	12	75		413	19
20	Sprinkler System Repairs, capitalized for Medicaid			2006	3,194		3			3,194	20
21	Installation of Data Outlet Recepticles for Medicaid			2007	4,160		3			4,160	21
22	Dry Wall - Entire Building			2007	10,329	1,033	10	1,033		4,648	22
23	3 Electric Water Heaters			2007	2,534	253	10	253		1,140	23
24	Phone System			2008	13,533	1,353	10	1,353		4,736	24
25	Metal Fire Door			2008	1,825	182	10	182		639	25
26	Paging System			2008	2,036	204	10	204		713	26
27	Dishmachine			2008	16,636	1,664	10	1,664		5,823	27
28	Smoke Detectors			2008	3,125	312	10	312		1,094	28
29	Window replacement (windows, sills, trim)			2009	40,527	4,503	9	4,503		11,258	29
30	Nurse Station			2009	56,951	6,328	9	6,328		15,820	30
31	Tile Floor			2009	13,887	1,543	9	1,543		3,857	31
32	Cabinet			2009	649	72	9	72		180	32
33	Electrical work (therapy kitchen)			2009	1,950	217	9	217		542	33
34	A/C Roof Unit Repair - capitalized for Medicaid			2009	2,948	983	3	983		2,457	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tank Heater	2010	$ 1,324	$ 165	8	$ 165	$	$ 248	37
38	A/C Units (4)	2010	2,099	420	5	420		630	38
39	A/C Units (3)	2010	1,626	203	8	203		305	39
40	Sewage Pump w/ Sump Pump	2010	637	80	8	80		119	40
41	A/C Unit	2010	538	108	5	108		161	41
42	Walk-In Freezer	2010	12,075	1,509	8	1,509		2,264	42
43	Repairs incurred from Lightning Strike - capitalized for Medicaid	2010	10,000	3,333	3	3,333		5,000	43
44	Water Softener System	2011	4,233	302	7	302		302	44
45	A/C Unit (5)	2011	2,688	269	5	269		269	45
46	Window Replacement	2011	47,741	3,410	7	3,410		3,410	46
47	Parking Lot Repairs capitalized for Medicaid	2011	2,600	433	3	433		433	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61	Note: See additional building improvements made by former								61
62	property owner Healthcare REIT, Inc. on supplemental								62
63	schedule included as page 24 of the cost report.								63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 620,920	$ 42,496		$ 42,496	$	$ 142,264	70

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 155,618	$ 24,958	$ 24,958	$		$ 83,333	71
72	Current Year Purchases	49,407	6,070	6,070			6,070	72
73	Fully Depreciated Assets	51,933					51,933	73
74								74
75	TOTALS	$ 256,958	$ 31,028	$ 31,028	$		$ 141,336	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 Wheel	2009	$ 36,675	$ 7,335	$ 7,335	$	5	$ 18,338	76
77										77
78										78
79										79
80	TOTALS			$ 36,675	$ 7,335	$ 7,335	$		$ 18,338	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)	$ 934,260	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 80,859	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 80,859	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)	$ 301,938	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Architect -Therapy Reno	$ 10,062	92
93			93
94			94
95		$ 10,062	95

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Health Care REIT, Inc for the period 1/1/11 thru 6/22/11
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. [X] 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:	1972	119	1/1/05	$ 180,991	6.5 years	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		119		$ 180,991 **			7

10. Effective dates of current rental agreement:
    Beginning 01/01/2005
    Ending 6/22/2011

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$ N/A
13.	/2013	$ N/A
14.	/2014	$ N/A

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: [X] YES [ ] NO Terms: exercised June 22, 2011 *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 33,808 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	N/A		$	$	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.

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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.

STATE OF ILLINOIS

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,970	$	1
2	Cash-Patient Deposits	23,691		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,040,209		3
4	Supply Inventory (priced at cost)	6,281		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,532		6
7	Other Prepaid Expenses	3,500		7
8	Accounts Receivable (owners or related parties)	(2,480,929)		8
9	Other(specify): Non resident A/R (see TB)	(425)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,390,171)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	47,769		16
17	Accumulated Depreciation (book methods)	(19,437)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(1,098)		21
22	Other Long-Term Assets (spe LongTermDeposit	1,075		22
23	Other(specify): Construction In Progress	10,062		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 38,371	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,351,800)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,625	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,254		28
29	Short-Term Notes Payable	3,789		29
30	Accrued Salaries Payable	153,356		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,339		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,480		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	34,284		36
37	Accrued Expenses	401,329		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 846,456	$	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)**	$ 846,456	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,198,256)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,351,800)	$	48

***(See instructions.)**

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC **#** 0046896 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,211,759)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,211,759)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(394,082)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	783,923	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(376,338)	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)**	$ 13,503	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,198,256)	24 *

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,550,644	1
2	Discounts and Allowances for all Levels	764,274	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,314,918	3
	B. Ancillary Revenue		
4	Day Care	98	4
5	Other Care for Outpatients		5
6	Therapy	523,397	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 523,495	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	2,378	14
15	Telephone, Television and Radio	480	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,775	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,633	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,940	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,940	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior Year Net Revenue	7,540	28
28a	Purchase Discounts	1,656	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,196	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,855,182	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	743,740	31
32	Health Care	2,627,023	32
33	General Administration	1,147,775	33
	B. Capital Expense		
34	Ownership	455,925	34
	C. Ancillary Expense		
35	Special Cost Centers	209,648	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,249,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	(394,082)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (394,082)	43

* **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 Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,000	1,107	$ 24,977	$ 22.56	1
2	Assistant Director of Nursing	1,744	2,080	42,765	20.56	2
3	Registered Nurses	9,185	10,358	227,616	21.97	3
4	Licensed Practical Nurses	18,599	20,952	373,623	17.83	4
5	CNAs & Orderlies	52,968	59,126	561,513	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,806	2,067	21,633	10.47	9
10	Activity Assistants	1,567	1,678	18,572	11.07	10
11	Social Service Workers	1,811	2,063	31,325	15.18	11
12	Dietician					12
13	Food Service Supervisor	1,360	1,823	21,671	11.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,014	8,723	78,228	8.97	15
16	Dishwashers	4,836	5,725	47,782	8.35	16
17	Maintenance Workers	1,906	2,100	30,313	14.43	17
18	Housekeepers	11,974	13,300	126,930	9.54	18
19	Laundry	4,592	5,303	47,015	8.87	19
20	Administrator	3,400	4,132	89,828	21.74	20
21	Assistant Administrator					21
22	Other Administrative	1,848	1,904	31,366	16.47	22
23	Office Manager	1,896	2,080	35,949	17.28	23
24	Clerical	1,735	1,972	20,217	10.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS	4,261	4,859	76,022	15.65	32
33	Other(specify) NRS Adm Clerical	1,764	1,988	23,477	11.81	33
34	TOTAL (lines 1 - 33)	136,266	153,340	$ 1,930,822 *	$ 12.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	282	15,600	9-3	36
37	Medical Records Consultant	16	517	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed	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	25	1,643	11-3	44
45	Social Service Consultant	25	1,643	12-3	45
46	Other(specify)				46
47	Medical Adm Record Preparation	$5.50/bed	7,854	10-3	47
48					48
49	TOTAL (lines 35 - 48)	347	$ 52,961		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,623	$ 133,565	10-3	50
51	Licensed Practical Nurses	2,578	99,215	10-3	51
52	Certified Nurse Assistants/Aides	2,600	58,976	10-3	52
53	TOTAL (lines 50 - 52)	6,801	$ 291,755		53

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Clark	Administrator	0	$ 74,907
Leah Henson	Bus. Office Ast	0	19,194
Patricia Hogan	Bus. Office Mgr	0	33,344
Nancy Willenburg	HR/Payroll	0	20,785
Jessie Bugg	Clerk	0	126
Christine Warcup	Admis Coordinator	0	22,448
Tamie Copley	Admis Coordinator	0	6,556
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 177,360

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 248,496
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 248,496

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,318
Freed, Maxick & Battaglia	Tax Fees	2,568
Various Legal Fees - See Attached detailed listing		67,207
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 72,093

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,865
Unemployment Compensation Insurance	58,075
FICA Taxes	146,604
Employee Health Insurance	136,087
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Worker Compensation Safety Rec. Prog.	500
Employee Benefits - other	11,069
Employee Benefit - Short Term Disability	419
Employee Benefit - Hepatitis B Vaccination	485
TOTAL (agree to Schedule V, line 22, col.8)	$ 457,104

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None in allowable cost (Column 8) of Schedule V		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,155
Advertising: Employee Recruitment	11,942
Health Care Worker Background Check	6,513
(Indicate # of checks performed 282)	
Sams Club & IL NH Admin Ass	135
Facility Advertising	4,916
IL. Health Care Association	6,569
Non Allowable IL Health Care Assn	(4,293)
Chamber of Commerce & JobMatch	162
Non Allowable Chamber of Commerce	(25)
Less: Public Relations Expense	( )
Non-allowable advertising	(4,916)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,158

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	42,369
Seminar Expense	4,450
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 46,819

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/11 Ending: 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $2,275 net of non-allowable**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,158** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,153**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes, see attached** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,378**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No personal use**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Improvements Made by Health Care REIT (covered by rent at outset		$	$		$	$	$	1
2	of Change of Ownership):								2
3									3
4	Ductwork	2005	65,173	3,259	20	3,259		21,181	4
5	EPDM Roof System	2005	213,004	21,300	10	21,300		138,453	5
6	Fire Alarm System	2005	30,608	3,061	10	3,061		19,895	6
7	Service Doors (2), Break Room Door (1)	2005	4,650	358	13	358		2,325	7
8	Drywall seven (7) rooms	2005	1,983	153	13	153		992	8
9	A/C Units	2006	18,612	1,861	5	1,861		18,612	9
10	Installation of Fire Alarm System	2006	1,820	182	10	182		1,001	10
11	Chair Rails	2006	2,380	198	12	198		1,091	11
12	Paint Ceilings in Resident Rooms	2006	3,825	383	5	383		3,825	12
13	Wall Repair and Painting of Facility	2006	55,141	5,514	5	5,514		55,141	13
14	A/C Unit 5 Ton	2006	3,600	360	10	360		1,980	14
15	Landscaping	2006	9,979	998	10	998		5,488	15
16	Sprinkler System	2006	169,310	14,109	12	14,109		77,600	16
17	Suspend Ceiling	2006	46,322	3,860	12	3,860		21,200	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 626,406	$ 55,596		$ 55,596	0	$ 368,784	34

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