

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY

0005785 Report Period Beginning: 9/1/13 Ending: 8/31/14

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,125	5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	4,838	9,643		14,481	10
11	ICF/DD					11
12	SC		7,688		7,688	12
13	DD 16 OR LESS					13
14	TOTALS	4,838	17,331		22,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.08%

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)

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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/2014 Fiscal Year: 8/31/2014

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

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	246,133	18,054	8,337	272,524		272,524		272,524		1
2	Food Purchase		195,216		195,216		195,216	(6,478)	188,738		2
3	Housekeeping	167,234	35,881	568	203,683		203,683		203,683		3
4	Laundry		1,124	1,999	3,123		3,123		3,123		4
5	Heat and Other Utilities			115,332	115,332		115,332		115,332		5
6	Maintenance	60,194	7,502	40,714	108,410		108,410		108,410		6
7	Other (specify):*										7
8	TOTAL General Services	473,561	257,777	166,950	898,288		898,288	(6,478)	891,810		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,194,505	44,547	26,301	1,265,353		1,265,353		1,265,353		10
10a	Therapy										10a
11	Activities	122,391	8,265	590	131,246		131,246		131,246		11
12	Social Services	53,974	1,993	1,195	57,162		57,162		57,162		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,370,870	54,805	28,086	1,453,761		1,453,761		1,453,761		16
	C. General Administration										
17	Administrative	87,107			87,107		87,107		87,107		17
18	Directors Fees										18
19	Professional Services			42,759	42,759		42,759		42,759		19
20	Dues, Fees, Subscriptions & Promotions			14,585	14,585		14,585	(261)	14,324		20
21	Clerical & General Office Expenses	135,626	7,809	121,669	265,104		265,104	(7,380)	257,724		21
22	Employee Benefits & Payroll Taxes			362,840	362,840		362,840		362,840		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,247	7,247		7,247		7,247		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,831	55,831		55,831		55,831		26
27	Other (specify):* Marketing		50	8,847	8,897		8,897	(8,897)			27
28	TOTAL General Administration	222,733	7,859	613,778	844,370		844,370	(16,538)	827,832		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,067,164	320,441	808,814	3,196,419		3,196,419	(23,016)	3,173,403		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.

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			72,330	72,330	72,330		72,330				30
31	Amortization of Pre-Op. & Org.			146,960	146,960	146,960		146,960				31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			219,290	219,290	219,290		219,290				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			23,755	23,755	23,755		23,755				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,311	115,311	115,311		115,311				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			139,066	139,066	139,066		139,066				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,067,164	320,441	1,167,170	3,554,775	3,554,775		(23,016)	3,531,759			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 RESTHAVE HOME WHITESIDE CNTY

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Report Period Beginning: 9/1/13

Ending: 8/31/14

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	(6,478)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,838)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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	(542)	21		24
25	Fund Raising, Advertising and Promotional	(8,897)	27		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(261)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,016)		\$	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)	\$ (23,016)		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

RESTHAVE HOME WHITESIDE CNTY

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	IHCA Dues - Portion for Lobbying	\$ (261)	20	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				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		(261)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY

0005785

Report Period Beginning:

9/1/13

Ending:

8/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,478)	0	0	0	0	0	0	0	0	0	0	(6,478)	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	(6,478)	0	0	0	0	0	0	0	0	0	0	(6,478)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(261)	0	0	0	0	0	0	0	0	0	0	(261)	20
21	Clerical & General Office Expenses	(7,380)	0	0	0	0	0	0	0	0	0	0	(7,380)	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):*	(8,897)	0	0	0	0	0	0	0	0	0	0	(8,897)	27
28	TOTAL General Administration	(16,538)	0	0	0	0	0	0	0	0	0	0	(16,538)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,016)	0	0	0	0	0	0	0	0	0	0	(23,016)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY

0005785

Report Period Beginning:

9/1/13

Ending:

8/31/14

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,016)	0	0	0	0	0	0	0	0	0	0	(23,016)	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

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Report Period Beginning:

9/1/13

Ending:

8/31/14

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	JOHN HAUPTMAN	BOARD MEMBER						1
2	JERRY LINDSEY	BOARD MEMBER						2
3	PHIL ECKLAND	BOARD MEMBER						3
4	ANNE FRAME	BOARD MEMBER						4
5	JANE PESSMAN	BOARD MEMBER						5
6	DOUGLAS LEECH	BOARD MEMBER						6
7	BARBARA AUSTIN	BOARD MEMBER						7
8	ROLAND EBBERS	BOARD MEMBER						8
9	DARLENE ECKLAND	BOARD MEMBER						9
10	MARGE SCHLEUNING	BOARD MEMBER						10
11	MARJORIE GIBSON	BOARD MEMBER						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

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	The National Bank		X	Fund expansion project	None		4,680,000	4,680,000	04/30/2015	0.0375							
7	City of Morrison		X	Revolving Fund	None	9/25/13	3,000,000	278,366	09/01/2023	0.0300							
8	Health Facilities Rev Bonds		X	Fund expansion project	None	10/30/13	7,020,000	7,020,000	10/01/2015	0.0300							
9	TOTAL Facility Related						\$ 14,700,000	\$ 11,978,366			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 14,700,000	\$ 11,978,366			\$						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$			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.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 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 This Page is N/A

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,787 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility Location</u>	<u>354,835</u>	<u>Various</u>	<u>\$ 10,977</u>	1
2	<u>Creek Street Property</u>	<u>2,500</u>	<u>2003</u>	<u>500</u>	2
3	TOTALS	<u>357,335</u>		<u>\$ 11,477</u>	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	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:

9/1/13

Ending:

8/31/14

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									66
67	Total Building & Improvements Depreciation			10,610		10,610		1,028,178	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,130,157	\$ 10,610		\$ 10,610	\$	\$ 1,028,178	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 353,530	\$ 39,753	\$ 39,753	\$	Various	\$ 165,210	71
72	Current Year Purchases	26,912	1,687	1,687		Various	1,687	72
73	Fully Depreciated Assets	807,620	3,506	3,506		Various	807,620	73
74								74
75	TOTALS	\$ 1,188,062	\$ 44,946	\$ 44,946	\$		\$ 974,517	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	Snow Plow	1985	\$ 1,450	\$	\$	\$	5	\$ 1,450	76
77	Maintenance	2012 Ford Van S2E	2012	48,130	9,626	9,626		5	24,867	77
78	Maintenance	2001 Dodge Ram 1500	2014	5,500				5		78
79										79
80	TOTALS			\$ 55,080	\$ 9,626	\$ 9,626	\$		\$ 26,317	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)	\$ 2,384,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,182	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,182	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)	\$ 2,029,012	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	Building Depreciation Adjustment	\$	\$ 1,597	\$	86
87	Equipment Depreciation Adjustment		2,171		87
88	Vehicle Depreciation Adjustment		3,380		88
89					89
90					90
91	TOTALS	\$	\$ 7,148	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Expansion Project	\$ 9,680,790	92
93			93
94			94
95		\$ 9,680,790	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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ _____ 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.

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY # 0005785 Report Period Beginning: 9/1/13 Ending: 8/31/14
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><u>CNA's have received training and certification prior to being hired.</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		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.

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY

0005785

Report Period Beginning: 9/1/13

Ending:

8/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/14 (last day of reporting year)

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	\$ 197,991	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	302,398		3
4	Supply Inventory (priced at)	12,195		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,686		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 517,270	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,123,412		12
13	Land	11,477		13
14	Buildings, at Historical Cost	1,043,250		14
15	Leasehold Improvements, at Historical Cost	86,907		15
16	Equipment, at Historical Cost	1,243,142		16
17	Accumulated Depreciation (book methods)	(2,030,112)		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 (spec CIP)	9,680,790		22
23	Other(specify): <u>Loan Fees</u>	176,336		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,335,202	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,852,472	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 58,670	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,081		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,811		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	87,854		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)	\$ 372,416	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	11,978,366		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)	\$ 11,978,366	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,350,782	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,501,690	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,852,472	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,819,492	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,819,492	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(317,801)	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) ROUNDING	(1)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (317,802)	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)	\$ 3,501,690	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 3,476,091		1
2	Discounts and Allowances for all Levels	(247,747)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,228,344		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		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	23,833		13
14	Non-Patient Meals	6,478		14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			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)	\$ 30,311		23
D. Non-Operating Revenue				
24	Contributions	10,939		24
25	Interest and Other Investment Income***	(49,071)		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (38,132)		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28	<u>Miscellaneous</u>	16,451		28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,451		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,236,974		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	898,288		31
32	Health Care	1,453,761		32
33	General Administration	844,370		33
B. Capital Expense				
34	Ownership	219,290		34
C. Ancillary Expense				
35	Special Cost Centers	23,755		35
36	Provider Participation Fee	115,311		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,554,775		40
41	Income before Income Taxes (line 30 minus line 40)**	(317,801)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (317,801)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 674,078	44
45	Private Pay - Net Inpatient Revenue	2,530,932	45
46	Medicare - Net Inpatient Revenue	23,334	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,228,344	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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:

9/1/13

Ending:

8/31/14

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	2,384	2,608	\$ 119,876	\$ 45.96	1
2	Assistant Director of Nursing	-	-	-	-	2
3	Registered Nurses	5,017	5,556	200,762	36.13	3
4	Licensed Practical Nurses	13,461	15,001	303,876	20.26	4
5	CNAs & Orderlies	47,195	51,546	519,623	10.08	5
6	CNA Trainees	-	-	-	-	6
7	Licensed Therapist	-	-	-	-	7
8	Rehab/Therapy Aides	-	-	-	-	8
9	Activity Director	1,811	2,080	35,340	16.99	9
10	Activity Assistants	7,261	7,986	87,051	10.90	10
11	Social Service Workers	2,201	2,573	53,974	20.98	11
12	Dietician	-	-	-	-	12
13	Food Service Supervisor	1,805	2,080	33,010	15.87	13
14	Head Cook	7,316	8,343	92,184	11.05	14
15	Cook Helpers/Assistants	9,901	10,946	120,939	11.05	15
16	Dishwashers	-	-	-	-	16
17	Maintenance Workers	3,892	4,222	60,194	14.26	17
18	Housekeepers	13,388	14,917	167,234	11.21	18
19	Laundry	-	-	-	-	19
20	Administrator	1,876	2,080	68,247	32.81	20
21	Assistant Administrator	-	-	-	-	21
22	Other Administrative	4,284	4,719	124,786	26.44	22
23	Office Manager	1,875	2,080	29,700	14.28	23
24	Clerical	-	-	-	-	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	1,707	2,048	29,468	14.39	31
32	Other Health C: <u>MDS Coordinator</u>	1,952	2,080	20,900	10.05	32
33	Other(specify)	-	-	-	-	33
34	TOTAL (lines 1 - 33)	127,323	140,864	\$ 2,067,164 *	\$ 14.67	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	78	\$ 5,056	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	53	5,348	10-3	38
39	Pharmacist Consultant	58	1,736	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	18	1,195	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	\$ 13,335		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-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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number RESTHAVE HOME WHITESIDE CNTY

0005785

Report Period Beginning:

9/1/13

Ending: 8/31/14

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. Illinois Healthcare Association, \$3,178
- (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. \$ 23,613 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 115,311
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. \$ 6,478
- (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 LLP
- (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.