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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0046896

Facility Name: White Hall Nsg & Rehab Ctr

Address: 620 W Bridgeport St (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) 972-2392
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 01/01/2015 to 12/31/2015 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)
(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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	27,088	7,003	5,417	39,508	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,088	7,003	5,417	39,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.96%

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

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

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

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

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 4,456

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 12/31/15 Fiscal Year: 1/1 to 12/31/15

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	231,348	22,891	15,816	270,055		270,055	(356)	269,699			1
2	Food Purchase		239,850		239,850		239,850	(8,653)	231,197			2
3	Housekeeping	166,683	22,488		189,171		189,171	(33)	189,138			3
4	Laundry	47,543	12,291	2,040	61,874		61,874	(827)	61,047			4
5	Heat and Other Utilities			101,135	101,135		101,135		101,135			5
6	Maintenance	40,342	43,275	25,571	109,188		109,188	(12,806)	96,382			6
7	Other (specify):* see trial balance			14,773	14,773		14,773		14,773			7
8	TOTAL General Services	485,916	340,795	159,335	986,046		986,046	(22,675)	963,371			8
	B. Health Care and Programs											
9	Medical Director			16,068	16,068		16,068		16,068			9
10	Nursing and Medical Records	2,103,034	172,583	26,264	2,301,881		2,301,881	(9,000)	2,292,881			10
10a	Therapy		5,310	864,439	869,749		869,749	(150,127)	719,622			10a
11	Activities	69,908	4,714	2,171	76,793		76,793		76,793			11
12	Social Services	67,986	1,416	1,671	71,073		71,073	(149)	70,924			12
13	CNA Training		690	4,990	5,680		5,680		5,680			13
14	Program Transportation			20,191	20,191		20,191	100	20,291			14
15	Other (specify):* see trial balance			14,123	14,123		14,123	(4,245)	9,878			15
16	TOTAL Health Care and Programs	2,240,928	184,713	949,917	3,375,558		3,375,558	(163,421)	3,212,137			16
	C. General Administration											
17	Administrative	288,967		358,536	647,503		647,503	(117,553)	529,950			17
18	Directors Fees											18
19	Professional Services			58,515	58,515		58,515	(2,281)	56,234			19
20	Dues, Fees, Subscriptions & Promotions			39,857	39,857		39,857	(25,123)	14,734			20
21	Clerical & General Office Expenses	26,693	109,347	34,796	170,836		170,836	(38,608)	132,228			21
22	Employee Benefits & Payroll Taxes			403,975	403,975		403,975	(1,614)	402,361			22
23	Inservice Training & Education											23
24	Travel and Seminar			38,842	38,842		38,842	588	39,430			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,283	44,283		44,283	(2,928)	41,355			26
27	Other (specify):* see trial balance			109,086	109,086		109,086	(75,711)	33,375			27
28	TOTAL General Administration	315,660	109,347	1,087,890	1,512,897		1,512,897	(263,230)	1,249,667			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,042,504	634,855	2,197,142	5,874,501		5,874,501	(449,326)	5,425,175			29

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr #0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			117,113	117,113		117,113	59,877	176,990			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25	25		25	273,894	273,919			32
33	Real Estate Taxes			79,598	79,598		79,598		79,598			33
34	Rent-Facility & Grounds			820,800	820,800		820,800	(820,800)				34
35	Rent-Equipment & Vehicles			31,431	31,431		31,431		31,431			35
36	Other (specify):* **Off Site Storage**			914	914		914		914			36
37	**TOTAL Ownership**			1,049,881	1,049,881		1,049,881	(487,029)	562,852			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,357	8,357		8,357		8,357			39
40	Barber and Beauty Shops			142	142		142		142			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			278,263	278,263		278,263		278,263			42
43	Other (specify):* **see trial balance**			251,328	251,328		251,328	(82,290)	169,038			43
44	**TOTAL Special Cost Centers**			538,090	538,090		538,090	(82,290)	455,800			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,042,504	634,855	3,785,113	7,462,472		7,462,472	(1,018,645)	6,443,827			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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(80,060)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,622)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25)	32		10
11	Discounts, Allowances, Rebates & Refunds	(125)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(200)	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	(146)	21		18
19	Entertainment				19
20	Contributions	(100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,146)	27		24
25	Fund Raising, Advertising and Promotional	(19,749)	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	(120,818)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (307,991)		$	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)	(710,654)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (710,654)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,018,645)		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

White Hall Nsg & Rehab Ctr

ID# 0046896

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues & Subscriptions	$ (5,097)	20	1
2	Remove Non-allow Admission Dues&Subscriptions	(135)	20	2
3	Remove Non-allowable Admissions Other Supplies	(23,296)	21	3
4	Remove Non-allowable Admin Books&Periodicls	(24)	21	4
5	Remove Non-allowable Insureance Cost	(2,928)	26	5
6	Remove Non-allowable Admin Other Supplies	(933)	21	6
7	Remove Non-allowable Admin Other Purch Svcs	(3,325)	27	7
8	Remove Non-allowable NRS Admin-Purch Svcs	(804)	15	8
9	Remove Non-allowable HR-EE background checks	(142)	20	9
10	Remove Non-allowable BO Tax Preparation Fees	(2,395)	19	10
11	Remove Non-allowable Outpatnt Svcs-consol billing	(2,227)	43	11
12	Addtl Allow Dietary Cleaning Supplies	68	1	12
13	Remove Non-allowable Dietary Other Supplies&Mats	(78)	1	13
14	Remove Non-allowable Dietary Raw Food	(2,831)	2	14
15	Remove Non-allowable Hskp-Non-Med Equipment	(33)	3	15
16	Remove Non-allowable Laundry - Laundry Soap	(827)	4	16
17	Addtl Allow Nrs Admin -Minor Non-Med Equip	510	10	17
18	Addtl Allow Nrs Admin-Other Supplies	223	10	18
19	Addtl Allow Nrs Admin Lodging	108	14	19
20	Remove Non-allowable NrsAdmin Book&Periodicls	(111)	15	20
21	Addtl Allow Admin Legal Services	114	19	21
22	Addtl Allow Admin Minor Non-Med Equipment	352	21	22
23	Remove Non-allowable Admin Other Supplies	(73)	21	23
24	Addtl Allow EE Benefit Group Health Ins	44	22	24
25	Addtl Allow EE Benefit Short Term Disability	33	22	25
26	Addtl Allow EE Benefit Life Insurance	100	22	26
27	Addtl Allow Admin Lodging	588	24	27
28	Addtl Allow Admin Data Processing	350	27	28
29	Remove Non-allowable IV Rx Drugs Cost	(5,093)	43	29
30	Remove Non-allowable Prior Year Costs	(1,742)	43	30
31	Offset Interco Sold Services Revenue	(1,196)	6	31
32	Offset Interco Sold Services Revenue	(2,350)	17	32
33	Offset Interco Sold Services Revenue	(2,477)	10	33
34	Offset Interco Sold Services Revenue	(346)	1	34
35	Offset Interco Sold Services Revenue	(149)	12	35
36	Offset Interco Sold Services Revenue	(973)	22	36
37	Offset Misc. Revenue Med Surg & Food Sup.	(1,676)	10	37
38	Offset Misc. Revenue Non-Med Equip	(372)	6	38
39	Offset Misc. Revenue Incontinent	(1,250)	10	39
40	Offset Misc. Revenue Other	(12)	21	40
41	Offset Misc. Revenue Other	(8)	14	41
42	Capitalize repairs & Maintenance & Equipment	(11,238)	6	42
43	Capitalize repairs & Maintenance & Equipment	(13,735)	21	43
44	Depreciation/Amort LHI	3,573	30	44
45	Depreciation/Amort MME	3,391	30	45
46	Current Year Depreciation Audit Adjustments LHI	(2,963)	30	46
47	Offset Outpatient Occupational Therapy Revenue	(37,683)	10a	47
48	Offset Outpatient Speech Therapy Revenue	(1,750)	10a	48
49	**Total**	(120,818)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(356)	0	0	0	0	0	0	0	0	0	0	(356)	1
2	Food Purchase	(8,653)	0	0	0	0	0	0	0	0	0	0	(8,653)	2
3	Housekeeping	(33)	0	0	0	0	0	0	0	0	0	0	(33)	3
4	Laundry	(827)	0	0	0	0	0	0	0	0	0	0	(827)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(12,806)	0	0	0	0	0	0	0	0	0	0	(12,806)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22,675)	0	0	0	0	0	0	0	0	0	0	(22,675)	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	(4,670)	(4,330)	0	0	0	0	0	0	0	0	0	(9,000)	10
10a	Therapy	(119,493)	(30,634)	0	0	0	0	0	0	0	0	0	(150,127)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(149)	0	0	0	0	0	0	0	0	0	0	(149)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	100	0	0	0	0	0	0	0	0	0	0	100	14
15	Other (specify):*	(915)	(3,330)	0	0	0	0	0	0	0	0	0	(4,245)	15
16	**TOTAL Health Care and Programs**	(125,127)	(38,294)	0	0	0	0	0	0	0	0	0	(163,421)	16
	C. General Administration													
17	Administrative	(2,350)	(115,203)	0	0	0	0	0	0	0	0	0	(117,553)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,281)	0	0	0	0	0	0	0	0	0	0	(2,281)	19
20	Fees, Subscriptions & Promotions	(25,123)	0	0	0	0	0	0	0	0	0	0	(25,123)	20
21	Clerical & General Office Expenses	(37,992)	(616)	0	0	0	0	0	0	0	0	0	(38,608)	21
22	Employee Benefits & Payroll Taxes	(796)	(818)	0	0	0	0	0	0	0	0	0	(1,614)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	588	0	0	0	0	0	0	0	0	0	0	588	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,928)	0	0	0	0	0	0	0	0	0	0	(2,928)	26
27	Other (specify):*	(84,221)	(321)	8,831	0	0	0	0	0	0	0	0	(75,711)	27
28	**TOTAL General Administration**	(155,103)	(116,958)	8,831	0	0	0	0	0	0	0	0	(263,230)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(302,905)	(155,252)	8,831	0	0	0	0	0	0	0	0	(449,326)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,001	0	55,876	0	0	0	0	0	0	0	0	59,877	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25)	0	273,919	0	0	0	0	0	0	0	0	273,894	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(820,800)	0	0	0	0	0	0	0	0	(820,800)	34
35	Rent-Equipment & Vehicles	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**	3,976	0	(491,005)	0	0	0	0	0	0	0	0	(487,029)	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):*	(9,062)	(73,228)	0	0	0	0	0	0	0	0	0	(82,290)	43
44	**TOTAL Special Cost Centers**	(9,062)	(73,228)	0	0	0	0	0	0	0	0	0	(82,290)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(307,991)	(228,480)	(482,174)	0	0	0	0	0	0	0	0	(1,018,645)	45

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Tara Pharmacy SE, LI	Birmingham	Pharmacy
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Tara Therapy, LLC	Orchard Park	Therapy
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare So	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	White Hall Property C	White Hall	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 N. H. Associates,	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Grou	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/l	Orchard Park	Support Office

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	27	Wireless Access Points License Fe	$ 321	Raimax Healthcare Solutions Group, LLC	0.00%	$	$ (321)	1
2	V	15	Patient Care Software	3,600	Raimax Healthcare Solutions Group, LLC	0.00%	74	(3,526)	2
3	V	15	Wireless Access Points License Fee	605	Raimax Healthcare Solutions Group, LLC	0.00%	801	196	3
4	V	21	Wireless Access Points	3,250	Raimax Healthcare Solutions Group, LLC	0.00%	2,416	(834)	4
5	V	10	Pharmacy Consulting Services	25,704	Tara Pharmacy SE, LLC	0.00%	21,677	(4,027)	5
6	V	43	FluVac/Prescription Drug-Residents	219,367	Tara Pharmacy SE, LLC	0.00%	146,139	(73,228)	6
7	V	22	Flu & TB Vaccines for Employees	1,931	Tara Pharmacy SE, LLC	0.00%	1,113	(818)	7
8	V	10	Misc. Sales & Delivery Charges	303	Tara Pharmacy SE, LLC	0.00%		(303)	8
9	V	10a	Physical Therapy Fees	407,990	Tara Therapy, LLC	0.00%	383,178	(24,812)	9
10	V	10a	Occupational Therapy Fees	327,916	Tara Therapy, LLC	0.00%	298,737	(29,179)	10
11	V	10a	Speech Therapy Fees	128,422	Tara Therapy, LLC	0.00%	151,779	23,357	11
12	V	17	Administrative Services Costs	358,536	Aurora Cares, LLC d/b/a Tara Cares	0.00%	243,333	(115,203)	12
13	V	21	Telephone Cost Reduction Project		Raimax Healthcare Solutions Group, LLC	0.00%	218	218	13
14	Total			$ 1,477,945			$ 1,249,465	$ * (228,480)	14

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 820,800	White Hall Property Company, LLC	0.00%	$	$ (820,800)	15
16	V	30	Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	37,363	37,363	16
17	V	30	Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	12,587	12,587	17
18	V	30	Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	5,926	5,926	18
19	V	27	Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	8,831	8,831	19
20	V	32	Interest -Capital /LongTerm		White Hall Property Company, LLC	0.00%	131,798	131,798	20
21	V	32	Interest - Working CapSwap		White Hall Property Company, LLC	0.00%	142,121	142,121	21
22	V	1	Dietary Services	14,031	Scenic Nursing and Rehabilitation Center, LLC	0.00%	14,031		22
23	V	15	Nursing AdminServices	863	Scenic Nursing and Rehabilitation Center, LLC	0.00%	863		23
24	V	15	Nursing Admin Services	1,408	Granite Nursing and Rehabilitation Center, LLC	0.00%	1,408		24
25	V	15	Nursing Admin Services	520	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	520		25
26	V	27	Business Office Services	163	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	163		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			$ 837,785			$ 355,611	$ * (482,174)	39

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	DTD HC, LLC	Owner		50.00	0	0	0.00	0	$ 0	17	1
2	D & N, LLC	Owner		50.00	0	0	0.00	0	0	17	2
3	Donald T. Denz	CFO & CoCEO		0.00	***	0.83	2.08	Fin/ Adm. of TC	6,166	17	3
4		for Tara Cares									4
5	Norbert A. Bennett	CEO for Tara Cares		0.00	***	0.83	2.08	Fin/ Adm. of TC	6,166	17	5
6											6
7	Suzette Wilson	Vice President		0.00	***	0.83	2.08	VP of TC	5,468	17	7
8											8
9											9
10	*** Compensation paid only through Support Office and allocated share reported in column 7.										10
11											11
12											12
13								TOTAL	$ 17,800		13

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	Total Costs	377,160,268	40	$ 341,807	$ 262,439	7,102,874	$ 6,439	1
2	5	Administrative Services Costs	Days	1,533,632	36	40,064	0	39,491	1,031	2
3	6	Administrative Services Costs	Days	1,533,632	36	85,860	0	39,491	2,212	3
4	10	Administrative Services Costs	Total Costs	377,160,268	40	2,765,952	2,197,104	7,102,874	52,075	4
5	17	Administrative Services Costs	Days	1,533,632	36	5,577,068	5,577,068	39,491	143,615	5
6	19	Administrative Services Costs	Days	1,533,632	36	10,399	0	39,491	268	6
7	20	Administrative Services Costs	Days	1,533,632	36	20,434	0	39,491	526	7
8	21	Administrative Services Costs	Days	1,533,632	36	248,288	0	39,491	6,391	8
9	22	Administrative Services Costs	Days	1,533,632	36	742,289	0	39,491	19,113	9
10	24	Administrative Services Costs	Days	1,533,632	36	139,206	0	39,491	3,584	10
11	26	Administrative Services Costs	Days	1,533,632	36	5,592	0	39,491	144	11
12	27	Administrative Services Costs	Days	1,533,632	36	104,557	0	39,491	2,692	12
13	30	Administrative Services Costs	Days	1,533,632	36	101,450	0	39,491	2,612	13
14	31	Administrative Services Costs	Days	1,533,632	36	13,775	0	39,491	355	14
15	33	Administrative Services Costs	Days	1,533,632	36	29,603	0	39,491	762	15
16	34	Administrative Services Costs	Days	1,533,632	36	57,221	0	39,491	1,473	16
17	35	Administrative Services Costs	Days	1,533,632	36	1,602	0	39,491	41	17
18										18
19										19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting faciltiy. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.								22
23										23
24										24
25	TOTALS					$ 10,285,167	$ 8,036,611		$ 243,333	25

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Niagara Bank		X	Land and Building	$27,885.00	2/28/14	$ 6,368,179	$ 6,107,711	2/28/34	LIBOR PI	$ 177,046	1
2	First Niagara Bank		X	Land and Building	$11,318.00	2/28/14	2,706,821	2,469,143	03/01/19	LIBOR PLUS	96,873	2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related				$39,203.00		$ 9,075,000	$ 8,576,854			$ 273,919	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,075,000	$ 8,576,854			$ 273,919	15

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

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr **#** 0046896 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 83,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 75,398	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,802)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 87,400	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.		$ 79,598	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	79,796	8
	2011	75,736	9
	2012	81,020	10
	2013	79,245	11
	2014	75,398	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nsg & Rehab Ctr COUNTY Greene

FACILITY IDPH LICENSE NUMBER 0046896

CONTACT PERSON REGARDING THIS REPORT Gary F. Eye

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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	$ 75,398.02	$ 75,398.02
2.		3W JC 536	$	$
3.		34-12-12	$	$
4.		PT N MID PT E1/2 SE	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,398.02	$ 75,398.02

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,655 B. General Construction Type: Exterior Brick Frame Metal Number of Stories One

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

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

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

None

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

1. Total Amount Incurred: 92,983
2. Number of Years Over Which it is Being Amortized: 5 years (60 Months)
3. Current Period Amortization: Included in Schedule VII B Ln 1-8
4. Dates Incurred: Various and on the books of related entities

Nature of Costs: Inc. Capitalized Pre-Opening Salaries, Benefirs&OtherCostsIncurred2009&2010. AllocatedViaRelatedOrgCost&ReportedSchVIIB
(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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 5,926	40	$ 5,926	$	$ 26,665	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	797	40	10	40		797	9
10	Generator Repairs, capitalized for Medicaid			2005	2,270		3			2,270	10
11	Auto Cad Design for Fire Alarm System			2006	1,080	108	10	108		1,026	11
12	Sign Pillars w/ Lighting			2006	8,975	898	10	898		8,526	12
13	Window Treatment			2006	13,663	1,366	10	1,366		12,980	13
14	Shower Room Renovations			2006	46,015	3,834	12	3,834		36,428	14
15	Measure & Install Blinds in Facility			2006	10,998		5			10,998	15
16	Handrail and Background Staining			2006	14,880	1,240	12	1,240		11,780	16
17	Electrical Wiring (lighting & smoke detectors)			2006	23,000	1,917	12	1,917		18,208	17
18	Sprinkler System Repairs, capitalized for Medicaid			2006	3,194		3			3,194	18
19	Installation of Data Outlet Recepticles for Medicaid			2007	4,160		3			4,160	19
20	Dry Wall - Entire Building			2007	10,329	1,033	10	1,033		8,780	20
21	3 Electric Water Heaters			2007	2,534	253	10	253		2,154	21
22	Phone System	REDUCED ON AUDIT		2007	10,021	1,002	10	1,002		7,515	22
23	Dish Machine	REDUCED ON AUDIT		2007	4,000	400	10	400		3,000	23
24	Smoke Detectors			2008	3,125	312	10	312		2,344	24
25	Window replacement (windows, sills, trim)			2009	40,527	4,503	9	4,503		29,270	25
26	Nurse Station			2009	56,951	6,328	9	6,328		41,131	26
27	Tile Floor			2009	13,887	1,543	9	1,543		10,029	27
28	A/C Roof Unit Repair - capitalized for Medicaid			2009	2,948		3			2,948	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

**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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	A/C Units (4)	2010	$ 2,099	$ 210	5	$ 210	$	$ 2,099	37
38	A/C Units (3)	2010	1,626	203	8	203		1,118	38
39	Walk-In Freezer	2010	12,075	1,509	8	1,509		8,302	39
40	RepairsFromLightningStrike-capMcdREDUCED ON AUDIT	2010	8,791		3			8,791	40
41	Water Softener System	2011	4,233	605	7	605		2,722	41
42	A/C Unit (5)	2011	2,688	538	5	538		2,419	42
43	Window Replacement	2011	47,741	6,820	7	6,820		30,691	43
44	Parking Lot Repairs capitalized for Medicaid	2011	2,600		3			2,600	44
45	A/C Units (4)	2012	2,372	474	5	474		1,660	45
46	Air Curtain	2012	721	48	15	48		168	46
47	Built-in AC Units (2)	2012	1,186	237	5	237		830	47
48	5-Ton AC Unit	2013	3,929	262	15	262		655	48
49	2 Built in AC Units	2013	1,258	252	5	252		629	49
50	Cabling - Wireless Upgrade	2013	3,539	177	20	177		442	50
51	Replaced Floor Tile in Dining Room and North Lounge	2013	17,016	1,702	10	1,702		4,254	51
52									52
53	AC Units - Built in (2)	2013	1,258	252	5	252		629	53
54	Flooring for Behavior Memory Unit	2014	29,355	2,935	10	2,935		4,403	54
55	A/C Unit 8.5 Ton Rooftop	2014	9,837	984	10	984		1,476	55
56	AC Units - Built in (18)	2014	12,680	2,536	5	2,536		3,804	56
57	AC Units - Built in (4)	2014	2,593	519	5	519		778	57
58	Smoker's Gazebo (1)	2014	2,693	269	10	269		404	58
59	18 Bed / Therapy Expansion - IDPH # L3619	2015	3,760,340	75,207	25	75,207		75,207	59
60	Replace 1,000 sq feet of asphalt pavement	2015	3,981	249	8	249		249	60
61									61
62									62
63	Note: See additional building improvements made by former		626,406	35,657		35,657		547,955	63
64	property owner Healthcare REIT, Inc. on supplemental								64
65	schedule included as page 24 of the cost report.								65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,071,394	$ 162,348		$ 162,348	$	$ 946,488	70

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 179,588	$ 20,330	$ 20,330	$	various	$ 98,089	71
72	Current Year Purchases	294,986	27,860	27,860		various	27,860	72
73	Fully Depreciated Assets	158,638	2,110	2,110		various	155,132	73
74								74
75	TOTALS	$ 633,212	$ 50,300	$ 50,300	$		$ 281,081	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Long Term Care	2009 Ford E250 Extended	2009	$ 36,675	$	$	$	5	$ 36,675	76
77		Wheelchair Van								77
78										78
79										79
80	TOTALS			$ 36,675	$	$	$		$ 36,675	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,760,988	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,648	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,648	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,264,244	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	None	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 31,431 Description: see separate schedule)
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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? [X] YES [ ] 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 [X]
- HOURS PER CNA 88

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER CNA 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 744	$ 4,051	$	$ 4,795
2	Books and Supplies	142	548		690
3	Classroom Wages (a)	0	0		
4	Clinical Wages (b)	0	0		
5	In-House Trainer Wages (c)	0	0		
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		195		195
9	TOTALS	$ 886	$ 4,794	$	$ 5,680
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,680			

C. CONTRACTUAL INCOME

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

$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	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): Billable oxygen(lbs)	39-3	18253	8,357				18,253	8,357	13
14	TOTAL			$ 8,357		$	$	18,253	$ 8,357	14

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 7,432	$	1
2	Cash-Patient Deposits	39,173		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,590,237		3
4	Supply Inventory (priced at cost)	7,108		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,931		6
7	Other Prepaid Expenses	16,039		7
8	Accounts Receivable (owners or related parties)	(311,873)		8
9	Other(specify): Non Resident A/R (see TB)	8,533		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,360,580	$	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	3,833,611		15
16	Equipment, at Historical Cost	381,445		16
17	Accumulated Depreciation (book methods)	(184,473)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(2,552)		21
22	Other Long-Term Assets (spe Deposits Long Term	1,175		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,029,206	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,389,786	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 187,834	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,965		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,901		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,813		31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,400		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	22,831		36
37	Accrued Expenses	215,585		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 894,329	$	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)**	$ 894,329	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,495,457	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,389,786	$	48

***(See instructions.)**

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,408,575	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,408,575	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(144,796)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,522,931	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(291,253)	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)**	$ 3,086,882	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,495,457	24 *

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,470,560	1
2	Discounts and Allowances for all Levels	1,126,197	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,596,757	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	119,493	5
6	Therapy	591,863	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 711,356	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	5,622	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,182	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,852	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,656	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,063	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,063	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Prior Year Net Revenue**	(18,533)	28
28a	**Purchase Discounts & Misc Revenue**	11,377	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (7,156)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,317,676	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	986,046	31
32	Health Care	3,375,558	32
33	General Administration	1,512,897	33
	B. Capital Expense		
34	Ownership	1,049,881	34
	C. Ancillary Expense		
35	Special Cost Centers	259,827	35
36	Provider Participation Fee	278,263	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,462,472	40
41	**Income before Income Taxes (line 30 minus line 40)****	(144,796)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (144,796)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,271,928	44
45	Private Pay - Net Inpatient Revenue	1,089,835	45
46	Medicare - Net Inpatient Revenue	2,194,980	46
47	Other-(specify) **Hospice Contract**	40,014	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,596,757	49

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

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

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

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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,952	2,080	$ 65,512	$ 31.50	1
2	Assistant Director of Nursing	1,976	2,080	54,432	26.17	2
3	Registered Nurses	9,258	10,025	236,652	23.61	3
4	Licensed Practical Nurses	26,042	28,092	566,829	20.18	4
5	CNAs & Orderlies	86,714	94,540	1,018,503	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,890	2,058	31,267	15.19	9
10	Activity Assistants	4,032	4,163	38,641	9.28	10
11	Social Service Workers	3,941	4,605	67,986	14.76	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	44,360	21.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,546	3,964	36,802	9.28	15
16	Dishwashers	15,350	16,462	150,186	9.12	16
17	Maintenance Workers	2,288	2,492	40,342	16.19	17
18	Housekeepers	14,925	16,331	166,683	10.21	18
19	Laundry	4,895	5,469	47,543	8.69	19
20	Administrator	1,976	2,072	109,867	53.02	20
21	Assistant Administrator					21
22	Other Administrative	5,767	6,255	110,778	17.71	22
23	Office Manager	1,634	1,904	37,217	19.55	23
24	Clerical	5,253	5,860	57,798	9.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,300	3,591	44,695	12.45	31
32	Other Health C: MDS Coordinator	3,277	3,591	109,464	30.48	32
33	Other(specify) Central Supply	729	794	6,947	8.75	33
34	TOTAL (lines 1 - 33)	200,601	218,508	$ 3,042,504 *	$ 13.92	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	240	16,068	9-3	36
37	Medical Records Consultant	16	560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	$18/bed/month	25,704	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,671	11-3	44
45	Social Service Consultant	27	1,671	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	310	$ 45,674		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy Turke	Administrator	0	$ 64,014
Lori McKinnon	Administrator	0	45,853
Melissa Eschbach	Bus. Office Mgr	0	37,218
Nancy Willenburg	HR/Payroll	0	33,240
Christine Warcup, Scott Phares	Admissions Director	0	43,585
L.Henson,K. Schutz,S.Phares	Bus. Office Ast	0	31,104
Christopher Cox	Admissions Assistant	0	33,953
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 288,967

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 358,536
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 358,536

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,462
Freed, Maxick & Battaglia	Tax Fees	2,395
Various Legal Fees - See attached detailed listing		53,658
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 58,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,044
Unemployment Compensation Insurance	66,808
FICA Taxes	230,615
Employee Health Insurance	6,995
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Safety Rec. Program	1,123
Employee Benefits - Other	12,817
Employee Benefits - S Term Disability/Life	404
Employee Benefits - Hepatitis B Vaccination	158
Employee Benefits- Life Insurance (ER)	1,048
Employee Benefits - Exchange,Tuition,Dental	989
Employee Benefits - H.S.A. (ER)	360
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,361

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

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

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,824
Advertising: Employee Recruitment	5,885
Health Care Worker Background Check	719
(Indicate # of checks performed 12)	
Resident Background Checks 112	1,120
Assoc of Nutrition of Food Professionals	155
IL. Health Care Association/Chamber/Econ D	7,275
Non-allowHealthCareAssn/ChamberC	(5,232)
Club memberships/Admin License Renew/NA	678
Citrix License Renew/Fingerprinting/Facility	22,059
Less: Public Relations Expense	( )
Non-allowable advertising	(19,749)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,734

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	37,287
Seminar Expense	2,143
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 39,430

**See instructions.

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 $2,043 net of non-allowables**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,023** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **278,263**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,622**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Facility Name & ID Number White Hall Nsg & Rehab Ctr # 0046896 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 O	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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Made by Health Care REIT (covered by rent at outset										9
10	of Change of Ownership):										10
11											11
12	Ductwork			2005	65,173	3,259	20	3,259		34,216	12
13	EPDM Roof System			2005	213,004	10,650	10	10,650		213,004	13
14	Fire Alarm System			2005	30,608	1,530	10	1,530		30,608	14
15	Service Doors (2), Break Room Door (1)			2005	4,650	358	13	358		3,757	15
16	Drywall seven (7) rooms			2005	1,983	153	13	153		1,602	16
17	A/C Units			2006	18,612		5			18,611	17
18	Installation of Fire Alarm System			2006	1,820	182	10	182		1,729	18
19	Chair Rails			2006	2,380	198	12	198		1,884	19
20	Paint Ceilings in Resident Rooms			2006	3,825		5			3,825	20
21	Wall Repair and Painting of Facility			2006	55,141		5			55,141	21
22	A/C Unit 5 Ton			2006	3,600	360	10	360		3,420	22
23	Landscaping			2006	9,979	998	10	998		9,480	23
24	Sprinkler System			2006	169,310	14,109	12	14,109		134,037	24
25	Suspend Ceiling			2006	46,322	3,860	12	3,860		36,641	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	Total (Lines 1 thru 33)				626,406	35,657		35,657		547,955	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 63