FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0005785

Facility Name: Resthave Home Whiteside Cnty

Address: 408 Maple Avenue (Number) Morrison (City) 61270 (Zip Code)

County: Whiteside

Telephone Number: (815) 772-4021 Fax # (815) 722-4583

HFS ID Number:

Date of Initial License for Current Owners: 5/22/1969

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Deb Freeland Telephone Number: 317-574-9100
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 9/1/15 to 8/31/16 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)	Tami Tegeler
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Deb Freeland Principal
	(Firm Name & Address)	CliftonLarsonAllen 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
	(Telephone)	317-574-9100 Fax # 317-574-9707

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 Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds ______

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,620	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,620	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,611	11,683	1,329	22,623	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,611	11,683	1,329	22,623	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.30%

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 [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 4/31/1969

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

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

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 8/31/16 Fiscal Year: 8/31/16

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

Facility Name & ID Number: Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	288,464	18,557	8,175	315,196		315,196		315,196			1
2	Food Purchase		236,761		236,761		236,761	(4,245)	232,516			2
3	Housekeeping	210,005	38,070	90	248,165		248,165		248,165			3
4	Laundry		1,717	2,859	4,576		4,576		4,576			4
5	Heat and Other Utilities			163,410	163,410		163,410		163,410			5
6	Maintenance	71,519	9,347	34,707	115,573		115,573		115,573			6
7	Other (specify):*											7
8	**TOTAL General Services**	569,988	304,452	209,241	1,083,681		1,083,681	(4,245)	1,079,436			8
	B. Health Care and Programs											
9	Medical Director			15,500	15,500		15,500		15,500			9
10	Nursing and Medical Records	1,587,416	84,538	45,929	1,717,883		1,717,883	(2,702)	1,715,181			10
10a	Therapy											10a
11	Activities	129,693	8,107	975	138,775		138,775		138,775			11
12	Social Services	79,253	123	1,086	80,462		80,462		80,462			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,796,362	92,768	63,490	1,952,620		1,952,620	(2,702)	1,949,918			16
	C. General Administration											
17	Administrative	86,239	350	20,900	107,489		107,489		107,489			17
18	Directors Fees											18
19	Professional Services			133,749	133,749		133,749		133,749			19
20	Dues, Fees, Subscriptions & Promotions			39,409	39,409		39,409	(3,079)	36,330			20
21	Clerical & General Office Expenses	159,098	10,738	215,789	385,625		385,625	(42,564)	343,061			21
22	Employee Benefits & Payroll Taxes			464,428	464,428		464,428		464,428			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,044	13,044		13,044	(256)	12,788			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,259	52,259		52,259		52,259			26
27	Other (specify):* Marketing	43,669	6,050	22,633	72,352		72,352	(72,352)				27
28	**TOTAL General Administration**	289,006	17,138	962,211	1,268,355		1,268,355	(118,251)	1,150,104			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,655,356	414,358	1,234,942	4,304,656		4,304,656	(125,198)	4,179,458			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			476,756	476,756		476,756		476,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			414,372	414,372		414,372		414,372			32
33	Real Estate Taxes			148,910	148,910		148,910		148,910			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,040,038	1,040,038		1,040,038		1,040,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			125,504	125,504		125,504		125,504			39
40	Barber and Beauty Shops			24,276	24,276		24,276	(6,591)	17,685			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,115	173,115		173,115		173,115			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			322,895	322,895		322,895	(6,591)	316,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,655,356	414,358	2,597,875	5,667,589		5,667,589	(131,789)	5,535,800			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 # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,735)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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	(29,251)	21		24
25	Fund Raising, Advertising and Promotional	(72,352)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule **See PG5A Attachment**	(26,451)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (131,789)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (131,789)		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.			$		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

Resthave Home Whiteside Cnty

ID# 0005785

Report Period Beginning: 9/1/15

Ending: 8/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IHCA Dues - AL	$ (1,849)	20	1
2	Miscellaneous Income	(13,313)	21	2
3	IHCA Dues - Portion for Lobbying	(1,230)	20	3
4	Marketing travel	(256)	24	4
5	Medical Supplies Revenue - AL	(2,702)	10	5
6	Barbre and Beauty Revenue - AL	(6,591)	40	6
7	Misc. Operating Income - AL	0	21	7
8	Guest Meals - AL	(510)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,451)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,245)	0	0	0	0	0	0	0	0	0	0	(4,245)	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**	(4,245)	0	0	0	0	0	0	0	0	0	0	(4,245)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,702)	0	0	0	0	0	0	0	0	0	0	(2,702)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,702)	0	0	0	0	0	0	0	0	0	0	(2,702)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,079)	0	0	0	0	0	0	0	0	0	0	(3,079)	20
21	Clerical & General Office Expenses	(42,564)	0	0	0	0	0	0	0	0	0	0	(42,564)	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	(256)	0	0	0	0	0	0	0	0	0	0	(256)	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):*	(72,352)	0	0	0	0	0	0	0	0	0	0	(72,352)	27
28	**TOTAL General Administration**	(118,251)	0	0	0	0	0	0	0	0	0	0	(118,251)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(125,198)	0	0	0	0	0	0	0	0	0	0	(125,198)	29

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	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	(6,591)	0	0	0	0	0	0	0	0	0	0	(6,591)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(6,591)	0	0	0	0	0	0	0	0	0	0	(6,591)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(131,789)	0	0	0	0	0	0	0	0	0	0	(131,789)	45

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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. [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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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 [X]

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	Triump		X	LOC		8/21/15	$ 40,000	$ 424,000	8/21/16	0.0525	$ 13,384	1
2	USDA		X	Association - organization		5/18/15	400,000	398,821	5/18/55	0.0350	17,525	2
3	USDA		X	Association - organization		5/18/15	7,020,000	7,020,000	5/18/55	0.0350	165,700	3
4				audit adjustment							(26,244)	4
5												5
	Working Capital											
6	Triump		X	Fund expansion project		9/21/15	4,680,000	4,649,282	9/21/55	0.0375	236,855	6
7	City of Morrison		X	Revolving Fund		9/25/13	300,000	223,901	9/21/23	0.0300	7,152	7
8												8
9	TOTAL Facility Related						$ 12,440,000	$ 12,716,004			$ 414,372	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 12,440,000	$ 12,716,004			$ 414,372	15

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.)

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2015 report.	$	199,460	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.)	$	148,910	2
3. Under or (over) accrual (line 2 minus line 1).	$	(50,550)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	199,460	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.	$	148,910	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Line
2011		8
2012		9
2013		10
2014	62,959	11
2015		12

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resthave Home Whiteside Cnty COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT Deb Freeland

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-17-352-015	Assisted Living Parcel	$ 26,067.00	$
2.	09-17-352-016	NH Building Parcel	$ 112,868.82	$ 112,868.82
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 138,935.82	$ 112,868.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ______ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

37 Assisted Living Units

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	25			1961	$ 140,758	$	30	$	$	$	4
5	49			1969	326,818		15-33				5
6											6
7											7
8											8
	Improvement Type**										
9	LAUNDRY REMODELING			1974	6,242		20				9
10	GARAGE			1976	2,235		20				10
11	ROCK GARAGE DRIVE			1976	85		10				11
12	GARAGE WIRING & DOOR CLOSURE			1980	1,021		10 TO 15				12
13	SEAL BACK DRIVEWAY			1980	660		5				13
14	FIREPROOF I-BEAM			1981	1,039		10				14
15	PATIENT REC ROOM			1982	127,130		30				15
16	LANDSCAPE ALONG DRIVE			1982	400		5				16
17	CEILINGS			1983	13,650		15				17
18	TREES, SHRUBS			1983	466		10				18
19	PORCH & ACCESS			1984	7,954		10 TO 20				19
20	SOUTH PORCH, ELEC DOOR			1984	394		10				20
21	CARPET ALL PORCHES			1984	1,400		10				21
22	TREES, SHRUBS			1984	2,081		10				22
23	ASPHALT SEAL PARKING LOT			1984	10,950		10				23
24	BASEMENT REPAIR			1985	2,947		10				24
25	SHRUBS, FLOWERS			1985	933		10				25
26	ACTIVATORS/RADIATORS			1986	585		10				26
27	HANDRAIL, RAMP, CARPET			1986	1,137		10				27
28	HEAT CONTROLS VALVES			1986	851		10				28
29	FLOWERS, WOOD CHIPS			1986	125		10				29
30	GAZEBO			1987	1,575		10				30
31	AIR CONDITIONING			1987	1,048		10				31
32	REROOFING/PORCH REPAIR			1988	14,500		10				32
33	DUCTS FOR KITCHEN EQUIPMENT			1989	1,910		20				33
34	BRICK FOR BUILDING			1989	8,500		25				34
35	OVERHANG ON BUILDING			1989	3,810		15				35
36	CARPET			1993	581		10				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 Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	
1	Totals from Page 12A, Carried Forward		$ 1,497,692	$		$	$	$	1
2	EXCAVATION - FISCHER EXCAVATING	2015	333,979		20				2
3	ASPHALT PAVING - FISCHER EXCAVATING	2015	130,367		20				3
4	LANDSCAPING - TWIN OAKS	2015	39,350		20				4
5	CONCRETE - NORTHWEST COMMERCIAL	2015	423,977		20				5
6	MASONRY - DIAMOND MASONRY	2015	62,600		20				6
7	GENERAL TRADES - LAMP INCORPORATED	2015	1,976,033		20				7
8	ROOFING - CPR ROOFING INC.	2015	267,184		20				8
9	DRYWALL - NIWC	2015	695,874		20				9
10	FLOORING - ROCKFORD CARPETLAND	2015	323,822		20				10
11	PAINTING - ALL TECH DECORATING	2015	103,080		20				11
12	PLUMBING - MOST PLUMBING	2015	795,841		20				12
13	FIRE PROTECTION - TRISTATE AUTOMATIC SPRINKLER	2015	284,644		20				13
14	HVAC - HEAT CO MECHANICAL	2015	988,190		20				14
15	ELECTRICAL - COMPLETE ELECTRIC	2015	961,263		20				15
16	Phase 3 Building	2015	5,059,576		20				16
17	Capitalized interest	2015	777,503		20				17
18	Phase 2 - Building improvement	2015	110,030		20				18
19	Soft Water Line t oMixing Valve	2016	2,352		15				19
20	Re-wire basement mechanical room	2016	3,600		39				20
21	Med Records & Dining Addition, walls, flooring, paint	2016	12,095		39				21
22									22
23									23
24									24
25	Adjustment to Assisted living		(1,386,204)						25
26									26
27									27
28									28
29									29
30	Total Buildings and Improvement Depreciation			357,055		357,055		1,356,749	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,462,848	$ 357,055		$ 357,055	$	$ 1,356,749	34

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	$ 758,186	$	$	$	Var	$	71
72	Current Year Purchases	83,134				Var		72
73	Fully Depreciated Assets	807,620				Var	807,620	73
74	Total Equipment Depreciation		97,024	97,024				74
75	TOTALS	$ 1,648,940	$ 97,024	$ 97,024	$		$ 807,620	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	Maintenance	2012 For Van S2E	2012	48,130				5		77
78	Maintenance	2001 Dodge Ram 1500	2014	5,500				5		78
79	Maintenance	Snow Plow Blade	2014	4,879	11,214	11,214		10	47,173	79
80	TOTALS			$ 58,509	$ 11,214	$ 11,214	$		$ 47,173	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,181,774	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 465,293	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 465,293	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)	$ 2,211,542	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg & Bldg Improvement 2015	$ 1,386,204	$	$	86
87	Assisted Living - Equipment 2015	242,563	11,463		87
88					88
89					89
90					90
91	TOTALS	$ 1,628,767	$ 11,463	$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] 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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 0 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	$ 0		$ 0	$ 0		$	1
2	Licensed Speech and Language Development Therapist		hrs			0				2
3	Licensed Recreational Therapist		hrs			0				3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):						0			12
13	Other (specify):						0			13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/16 (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	$ 35,302	$	1
2	Cash-Patient Deposits	(4,971)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	708,769		3
4	Supply Inventory (priced at)	11,120		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,682		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(118,002)		8
9	Other(specify):	118,002		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 769,902	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	431,411		12
13	Land	11,477		13
14	Buildings, at Historical Cost	14,734,638		14
15	Leasehold Improvements, at Historical Cost	96,369		15
16	Equipment, at Historical Cost	1,937,791		16
17	Accumulated Depreciation (book methods)	(2,886,711)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Fees	51,363		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,376,338	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,146,240	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,429	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	324,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	63,891		31
32	Accrued Real Estate Taxes(Sch.IX-B)	199,460		32
33	Accrued Interest Payable	90,960		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)**	$ 818,904	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,675,262		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,675,262	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,494,166	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,652,074	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,146,240	$	48

*(See instructions.)

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,214,251	1
2	Restatements (describe):	19,907	2
3	Prior Year Adjustment		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,234,158	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(582,084)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (582,084)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,652,074	24 *

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

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	$ 4,270,658	1
2	Discounts and Allowances for all Levels	(761,326)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,509,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	448,450	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 448,450	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,015	13
14	Non-Patient Meals	3,735	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	150	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 62,287	23
	D. Non-Operating Revenue		
24	Contributions	19,813	24
25	Interest and Other Investment Income***	16,708	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,521	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Assisted Living	1,015,602	28
28a	Miscellaneous	13,313	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,028,915	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,085,505	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,083,681	31
32	Health Care	1,952,620	32
33	General Administration	1,268,355	33
	B. Capital Expense		
34	Ownership	1,040,038	34
	C. Ancillary Expense		
35	Special Cost Centers	149,780	35
36	Provider Participation Fee	173,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,667,589	40
41	**Income before Income Taxes (line 30 minus line 40)****	(582,084)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (582,084)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,234,130	44
45	Private Pay - Net Inpatient Revenue	2,311,842	45
46	Medicare - Net Inpatient Revenue	(41,066)	46
47	Other-(specify) Insurance/Hospice	4,426	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,509,332	49

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

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

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

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

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,083	2,163	$ 123,824	$ 57.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,708	8,175	272,671	33.35	3
4	Licensed Practical Nurses	17,731	19,436	402,777	20.72	4
5	CNAs & Orderlies	65,851	70,131	746,504	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,805	2,080	36,964	17.77	9
10	Activity Assistants	8,342	8,879	92,730	10.44	10
11	Social Service Workers	3,558	3,813	79,253	20.78	11
12	Dietician					12
13	Food Service Supervisor	1,870	2,080	33,724	16.21	13
14	Head Cook	7,184	7,920	91,081	11.50	14
15	Cook Helpers/Assistants	13,638	14,854	163,659	11.02	15
16	Dishwashers					16
17	Maintenance Workers	5,409	5,785	71,519	12.36	17
18	Housekeepers	18,338	19,572	210,005	10.73	18
19	Laundry					19
20	Administrator	1,904	2,357	75,677	32.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,850	2,080	83,422	40.11	23
24	Clerical	5,572	5,992	86,239	14.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,525	1,735	17,710	10.21	31
32	Other Health C: MDS Coordinator	1,952	2,080	23,927	11.50	32
33	Other(specify) Marketing	1,870	2,080	43,669	20.99	33
34	TOTAL (lines 1 - 33)	168,190	181,212	$ 2,655,355 *	$ 14.65	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	107	$ 8,175	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	18	1,833	10-3	38
39	Pharmacist Consultant	143	4,280	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	1,086	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	284	$ 15,374		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tami Tegeler	Administrator	0	$ 75,677
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,677

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	$ 96,671
Nelson, Kilgus, Richey & Buckwalter	Legal	450
Steven Pearlman & Associates	Legal	11,182
CliftonLarsonAllen	Accounting	35,446
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 143,749

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,810
Unemployment Compensation Insurance	
FICA Taxes	215,452
Employee Health Insurance	173,558
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	7,044
Employee Physicals	7,511
Employee Life Insurance	2,053
TOTAL (agree to Schedule V, line 22, col.8)	$ 464,428

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 19)	1,325
Patient Background Checks	
Dues & Memberships	15,591
Taxes and licenses	17,531
IHCA dues	4,962
Less IHCA AL and lobbying	(3,079)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,330

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,526
Related meals	256
Less Marketing meals	(256)
Seminar Expense	8,262
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,788

**See instructions.

Facility Name & ID Number Resthave Home Whiteside Cnty # 0005785 Report Period Beginning: 9/1/15 Ending: 8/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,962**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,988** Line **10**

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

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

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

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

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

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,735**

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

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen**

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