

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0050625</u></p> <p>Facility Name: <u>Whispering Oaks</u></p> <p>Address: <u>201 Spring Street</u> <u>Rosiclare</u> <u>62982</u> Number City Zip Code</p> <p>County: <u>Hardin</u></p> <p>Telephone Number: <u>(618)285-6974</u> Fax # <u>(618) 289-4860</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/28/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:15%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Date) _____ (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Date) _____ (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																												

Facility Name & ID Number Whispering Oaks

0050625 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	2,445			2,445	13
14	TOTALS	2,445			2,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.87%

D. How many bed-hold days during this year were paid by the Department?

None (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)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 2/28/2006

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Whispering Oaks # 0050625 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	11,699	1,158	258	13,115		13,115	502	13,617		1
2	Food Purchase		14,129		14,129		14,129	(198)	13,931		2
3	Housekeeping		2,318		2,318		2,318	9	2,327		3
4	Laundry		467		467		467		467		4
5	Heat and Other Utilities			12,916	12,916		12,916	(50)	12,866		5
6	Maintenance		1,119	7,152	8,271		8,271	274	8,545		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	11,699	19,191	20,326	51,216		51,216	537	51,753		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	149,337	6,329	6,866	162,532		162,532	(2,243)	160,289		10
10a	Therapy										10a
11	Activities		481	68	549		549		549		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	149,337	6,810	10,534	166,681		166,681	(2,243)	164,438		16
	C. General Administration										
17	Administrative			57,000	57,000		57,000	(20,500)	36,500		17
18	Directors Fees										18
19	Professional Services			2,346	2,346		2,346	2,036	4,382		19
20	Dues, Fees, Subscriptions & Promotions			3,152	3,152		3,152	53	3,205		20
21	Clerical & General Office Expenses		269	2,371	2,640		2,640	5,855	8,495		21
22	Employee Benefits & Payroll Taxes			28,849	28,849		28,849	3,274	32,123		22
23	Inservice Training & Education							11	11		23
24	Travel and Seminar							5	5		24
25	Other Admin. Staff Transportation			431	431		431	461	892		25
26	Insurance-Prop.Liab.Malpractice			5,906	5,906		5,906	65	5,971		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration		269	100,055	100,324		100,324	(8,740)	91,584		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	161,036	26,270	130,915	318,221		318,221	(10,446)	307,775		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

Whispering Oaks

#0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,873	21,873		21,873	1,476	23,349			30
31	Amortization of Pre-Op. & Org.							1,174	1,174			31
32	Interest			16,917	16,917		16,917	1,520	18,437			32
33	Real Estate Taxes			5,285	5,285		5,285	30	5,315			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,615	4,615		4,615	105	4,720			35
36	Other (specify):*											36
37	TOTAL Ownership			48,690	48,690		48,690	4,305	52,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			28,280	28,280		28,280		28,280			42
43	Other (specify):*		9	3,102	3,111		3,111	(3,111)				43
44	TOTAL Special Cost Centers		9	31,382	31,391		31,391	(3,111)	28,280			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	161,036	26,279	210,987	398,302		398,302	(9,252)	389,050			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(207)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,381)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	139	30		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	(11)	43		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	(1,351)	43		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				24
25	Fund Raising, Advertising and Promotional	(195)	43		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 Page 5A	(2,510)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,516)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,736)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,736)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,252)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Whispering Oaks

ID# 0050625

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Disallowed Special Events	(173)	43	1
2	Offset Transportation Revenue	(2,258)	12	2
3	Offset Refund on Co-Op Electricity	(79)	5	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,510)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Whispering Oaks# 0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	502	0	0	0	0	0	0	0	0	0	502	1
2	Food Purchase	(207)	9	0	0	0	0	0	0	0	0	0	(198)	2
3	Housekeeping	0	9	0	0	0	0	0	0	0	0	0	9	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(79)	29	0	0	0	0	0	0	0	0	0	(50)	5
6	Maintenance	0	274	0	0	0	0	0	0	0	0	0	274	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(286)	823	0	0	0	0	0	0	0	0	0	537	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15	0	0	0	0	0	0	0	0	0	15	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	(2,258)	0	0	0	0	0	0	0	0	0	0	(2,258)	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	(2,258)	15	0	0	0	0	0	0	0	0	0	(2,243)	16
	C. General Administration													
17	Administrative	0	(20,500)	0	0	0	0	0	0	0	0	0	(20,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,279	0	757	0	0	0	0	0	0	0	2,036	19
20	Fees, Subscriptions & Promotions	0	0	53	0	0	0	0	0	0	0	0	53	20
21	Clerical & General Office Expenses	0	0	5,855	0	0	0	0	0	0	0	0	5,855	21
22	Employee Benefits & Payroll Taxes	0	0	3,274	0	0	0	0	0	0	0	0	3,274	22
23	Inservice Training & Education	0	0	11	0	0	0	0	0	0	0	0	11	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	461	0	0	0	0	0	0	0	0	461	25
26	Insurance-Prop.Liab.Malpractice	0	0	65	0	0	0	0	0	0	0	0	65	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(19,221)	9,724	757	0	0	0	0	0	0	0	(8,740)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,544)	(18,383)	9,724	757	0	0	0	0	0	0	0	(10,446)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	139	0	1,296	41	0	0	0	0	0	0	0	1,476	30
31	Amortization of Pre-Op. & Org.	0	0	0	1,174	0	0	0	0	0	0	0	1,174	31
32	Interest	0	0	38	1,482	0	0	0	0	0	0	0	1,520	32
33	Real Estate Taxes	0	0	30	0	0	0	0	0	0	0	0	30	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	105	0	0	0	0	0	0	0	0	105	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	139	0	1,469	2,697	0	0	0	0	0	0	0	4,305	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):*	(3,111)	0	0	0	0	0	0	0	0	0	0	(3,111)	43
44	TOTAL Special Cost Centers	(3,111)	0	0	0	0	0	0	0	0	0	0	(3,111)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,516)	(18,383)	11,193	3,454	0	0	0	0	0	0	0	(9,252)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 502	\$ 502	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	9	9	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	9	9	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	29	29	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	274	274	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	15	15	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	57,000	Petersen Health Care Management, Inc.	100.00%	36,500	(20,500)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	1,279	1,279	12
13	V							13
14	Total		\$ 57,000			\$ 38,617	\$ * (18,383)	14

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

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 53	\$	53	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	5,855		5,855	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	3,274		3,274	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	11		11	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	5		5	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	461		461	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	65		65	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	1,296		1,296	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	38		38	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	30		30	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	105		105	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		\$			\$ 11,193	\$ *	11,193	39

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

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	757	757	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	41	41	33	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	1,174	1,174	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	1,482	1,482	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 3,454	\$ *	3,454	39

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

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Whispering Oaks # 0050625 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

0050625

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,521,544	75	\$ 312,540	\$ 357,910	2,445	\$ 502	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	2,445	9	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	2,445	9	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	2,445	29	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	2,445	274	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	2,445	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	2,445	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	2,445	15	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	2,445	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	2,445	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	2,445	36,500	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	2,445	1,279	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	2,445	53	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	2,445	5,855	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	2,445	3,274	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	2,445	11	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	2,445	5	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	2,445	461	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	2,445	65	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	2,445	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	2,445	1,296	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	2,445	38	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	2,445	30	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	2,445	105	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 49,810	25

Facility Name & ID Number Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Network, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309)691-8113
 Fax Number (309)691-8622

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	251,294	13	\$	2,445	\$	1
2	2	Food	Resident Days	251,294	13		2,445		2
3	3	Housekeeping	Resident Days	251,294	13		2,445		3
4	4	Laundry	Resident Days	251,294	13		2,445		4
5	5	Utilities	Resident Days	251,294	13		2,445		5
6	6	Maintenance	Resident Days	251,294	13		2,445		6
7	7	Mgmt. Allocation of Benefits	Resident Days	251,294	13		2,445		7
8	10	Nursing and Medical Records	Resident Days	251,294	13		2,445		8
9	15	Mgmt. Allocation of Benefits	Resident Days	251,294	13		2,445		9
10	17	Administrative	Resident Days	251,294	13		2,445		10
11	19	Professional Services	Resident Days	251,294	13	77,776	2,445	757	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	251,294	13		2,445		12
13	21	Clerical and General Office	Resident Days	251,294	13		2,445		13
14	22	Employee Benefits & Payroll	Resident Days	251,294	13		2,445		14
15	23	Inservice Training & Education	Resident Days	251,294	13		2,445		15
16	24	Travel and Seminar	Resident Days	251,294	13		2,445		16
17	25	Other Admin. Staff Transport.	Resident Days	251,294	13		2,445		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	251,294	13		2,445		18
19	30	Depreciation	Resident Days	251,294	13	4,252	2,445	41	19
20	31	Amortization	Resident Days	251,294	13	120,699	2,445	1,174	20
21	32	Interest	Resident Days	251,294	13	152,300	2,445	1,482	21
22	33	Real Estate Taxes	Resident Days	251,294	13		2,445		22
23	34	Rent-Facility and Grounds	Resident Days	251,294	13		2,445		23
24	35	Rent-Equipment & Vehicles	Resident Days	251,294	13		2,445		24
25	TOTALS					\$ 355,027	\$	\$ 3,454	25

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 413,015	\$ 327,206	12/31/34	Varies	\$ 16,917	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 413,015	\$ 327,206			\$ 16,917	9						
B. Non-Facility Related*																		
10												10						
11									Home Office Allocation-PHN		1,482	11						
12									Home Office Allocation-PHCM		38	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 1,520	14						
15	TOTALS (line 9+line14)						\$ 413,015	\$ 327,206			\$ 18,437	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	5,292	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.)		\$	5,213	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(79)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	5,364	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. Home Office Allocation		\$	30	
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.		\$	5,315	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	4,945	8
	2012	5,034	9
	2013	5,193	10
	2014	5,139	11
	2015	5,213	12

Accrual based on prior year tax bill.

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 Whispering Oaks COUNTY Hardin

FACILITY IDPH LICENSE NUMBER 0050625

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-82-057-08-000</u>	<u>Long-Term Care Facility</u>	\$ <u>5,212.92</u>	\$ <u>5,212.92</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>5,212.92</u></u>	\$ <u><u>5,212.92</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Whispering Oaks

0050625 Report Period Beginning:

1/1/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,320 B. General Construction Type: Exterior Vinyl Siding Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 1,174 4. Dates Incurred: 2013-2014

Nature of Costs:

(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	<u>Facility</u>	<u>10,000</u>	<u>2006</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	10,000		\$ 10,000	3

Facility Name & ID Number Whispering Oaks

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	2006	1994	\$ 530,000	\$	25	\$ 21,200	\$ 21,200	\$ 222,442
5									
6									
7									
8									
Improvement Type**									
9	A/C Unit		2009	2,985		5			2,985
10	A/C Unit		2010	3,860		15	258	258	1,677
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Building Booked				21,200			(21,200)	
32	Building Improvement Booked				257			(257)	
33									
34	2016-Home Office Allocation-Building Improvements			1,079			26	26	
35	2016-Home Office Allocation-Land Improvements			99			6	6	
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 Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 538,023	\$ 21,457		\$ 21,490	\$ 33	\$ 227,104	70

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

Facility Name & ID Number Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	\$ 4,098	\$ 222	\$ 409	\$ 187	5-10 yrs.	\$ 3,111	71
72	Current Year Purchases	2,031	194	145	(49)	7 yrs.	145	72
73	Fully Depreciated Assets	65,507					65,507	73
74	Home Office Allocation			1,305	1,305			74
75	TOTALS	\$ 71,636	\$ 416	\$ 1,859	\$ 1,443		\$ 68,763	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										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 619,659	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,873	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,349	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,476	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 295,867	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		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94	N/A		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 Whispering Oaks

0050625

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,720 Description: See Attached Schedule 14A

(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	<u>N/A</u>				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.

Whispering Oaks

0050625

Period Beginning 1/1/2016

Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	3,337
Laundry Equipment		35
Copier		1,243
Home Office Allocation		105
		<u>4,720</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number **Whispering Oaks**# **0050625**Report Period Beginning: **1/1/2016**Ending: **12/31/2016****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2016**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 110,378	\$ 110,378	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 918)	32,778	32,778	3
4	Supply Inventory (priced at Cost)	1,616	1,616	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,056	5,056	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	285	285	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 150,113	\$ 150,113	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	530,000	531,079	14
15	Leasehold Improvements, at Historical Cost	6,845	6,944	15
16	Equipment, at Historical Cost	71,636	71,636	16
17	Accumulated Depreciation (book methods)	(298,838)	(295,867)	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 (spe A/R-Prior Owner)	37,644	37,644	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 357,287	\$ 361,436	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 507,400	\$ 511,549	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,051	\$ 4,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,524	10,524	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,941	3,941	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,364	5,364	32
33	Accrued Interest Payable	1,442	1,442	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,120	2,120	36
37	Accrued Management Fees	72,006	72,006	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 99,448	\$ 99,448	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	327,206	327,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 327,206	\$ 327,206	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 426,654	\$ 426,654	46
47	TOTAL EQUITY(page 18, line 24)	\$ 80,746	\$ 84,895	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 507,400	\$ 511,549	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 223,635	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 223,634	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(142,888)	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)	\$ (142,888)	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)	\$ 80,746	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Whispering Oaks# 0050625Report Period Beginning: 1/1/2016Ending: 12/31/2016**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 252,870	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 252,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	207	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 207	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,258	28
28a	<u>Miscellaneous Revenue</u>	79	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,337	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 255,414	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	51,216	31
32	Health Care	166,681	32
33	General Administration	100,324	33
B. Capital Expense			
34	Ownership	48,690	34
C. Ancillary Expense			
35	Special Cost Centers	3,111	35
36	Provider Participation Fee	28,280	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 398,302	40
41	Income before Income Taxes (line 30 minus line 40)**	(142,888)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (142,888)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 252,870	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 252,870	49

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

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

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

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

Facility Name & ID Number Whispering Oaks

0050625

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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				1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	1,320	1,320	11,699	8.86
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	16,495	16,495	149,337	9.05
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	17,815	17,815	\$ 161,036 *	\$ 9.04

* 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	4	\$ 258	L1, C3
36	Medical Director	Monthly	3,600	L9,C3
37	Medical Records Consultant			
38	Nurse Consultant			
39	Pharmacist Consultant	Monthly	519	L10, C3
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant	6	347	L10A, C3
43	Speech Therapy Consultant			
44	Activity Consultant			
45	Social Service Consultant			
46	Other(specify)			
47				
48				
49	TOTAL (lines 35 - 48)	10	\$ 4,723	

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jessica Hershey	Administrator	0	\$ 36,500	Workers' Compensation Insurance	\$ 8,809	IDPH License Fee	\$	
				Unemployment Compensation Insurance	4,480	Advertising: Employee Recruitment		
				FICA Taxes	12,006	Health Care Worker Background Check		
				Employee Health Insurance	3,274	(Indicate # of checks performed <u>9</u>)	(90)	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	335	
				Employee Relations	280	Miscellaneous Dues & Subscriptions	2,907	
				Home Office Allocation	3,274	Home Office Allocation	53	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 36,500					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 57,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 57,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Shawnee Communications	Computer Services		\$ 580				Out-of-State Travel	\$
Honkamp Krueger	Computer Services		1,026					
E-Health	Computer Services		740	N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	5
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,346	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 5

* Attach copy of IMRF notifications

**See instructions.

Whispering Oaks
0050625
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,346

Home Office Allocation

Lucie, Scalf, and Bougher	Legal	6
Miscellaneous	Legal	2
Miller Hall and Triggs	Legal	10
Healthcare Resources International	Legal	118
Hunziker Law	Legal	12
Lexis Nexis	Legal	1
Wells Fargo	Legal	54
CliftonLarson Allen	Accountants	51
Ginoli & Co.	Accountants	659
Wells Fargo	Accountants	141
Miscellaneous	Computer Services	6
Change Healthcare	Computer Services	1
PTC Select	Computer Services	1
Advanced Answers on Demand	Computer Services	450
Stratus Networks	Computer Services	46
Kemper Technology	Computer Services	30
AT&T	Computer Services	1
Ability Network	Computer Services	192
CIAN	Computer Services	23
Comcast	Computer Services	4
CCH	Computer Services	2
Charter Communications	Computer Services	4
Allscripts	Computer Services	67
ATS	Computer Services	30
Allpayer Exchange	Computer Services	2
Optimizer	Other Prof Fees	5
Ankura	Other Prof Fees	35
David Budde	Other Prof Fees	4
Bruner, Cooper, Zuck	Other Prof Fees	10
Marotta, Gund, Budd, Dzerda	Other Prof Fees	63
Professional Software and Services	Other Prof Fees	3
Hughes Valuation Services	Other Prof Fees	3
Alan Litwiller	Other Prof Fees	-

Total (agree to Schedule V, line 19, column 8)	<u>4,382</u>
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Facility Name & ID Number Whispering Oaks# 0050625Report Period Beginning: 1/1/2016Ending: 12/31/2016**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 \$2907
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,005 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 28,280
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. \$ 207
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,258
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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? Yes
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: Ginoli and Company
- (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. No
Attach invoices and a summary of services for all architect and appraisal fees

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-9,252	equal to	-9,252	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	18,437	equal to	18,437	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	5,315	equal to	5,315	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	1,174	equal to	1,174	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	23,349	equal to	23,349	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	4,720	equal to	4,720	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services		equal to	0	#VALUE!	#VALUE!	Pg16 Z12+Z14..	N/A;B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	51,216	equal to	51,216	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	166,681	equal to	166,681	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	100,324	equal to	100,324	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	48,690	equal to	48,690	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	3,111	equal to	3,111	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	28,280	equal to	28,280	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	149,337	equal to	149,337	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		#VALUE!	#VALUE!	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		#VALUE!	#VALUE!	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	11,699	equal to	11,699	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	0	equal to		#VALUE!	#VALUE!	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		#VALUE!	#VALUE!	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	0	equal to	36,500	-36,500	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		#VALUE!	#VALUE!	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	161,036	equal to	161,036	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	258	< or = to	258	0	FAILED	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,600	< or = to	3,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	865	< or = to	6,866	-6,001	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	68	-68	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	36,500	equal to	36,500	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	57,000	equal to	57,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	2,346	equal to	2,346	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	32,123	equal to	32,123	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,205	equal to	3,205	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5	equal to	5	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	28,280	equal to	28,280	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-3,736	equal to	-3,736	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	327,206	equal to	327,206	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	5,364	equal to	5,364	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	538,023	equal to	538,023	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	71,636	equal to	71,636	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	295,867	equal to	295,867	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	80,746	equal to	80,746	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-142,888	equal to	-142,888	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	507,400	equal to	507,400	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	11,699	1,158	258	13,115	0	13,115	502	13,617
2. Food Purchase	0	14,129	0	14,129	0	14,129	-198	13,931
3. Housekeeping	0	2,318	0	2,318	0	2,318	9	2,327
4. Laundry	0	467	0	467	0	467	0	467
5. Heat and Other Utilities	0	0	12,916	12,916	0	12,916	-50	12,866
6. Maintenance	0	1,119	7,152	8,271	0	8,271	274	8,545
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	11,699	19,191	20,326	51,216	0	51,216	537	51,753
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	149,337	6,329	6,866	162,532	0	162,532	-2,243	160,289
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	481	68	549	0	549	0	549
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	149,337	6,810	10,534	166,681	0	166,681	-2,243	164,438
17. Administrative	0	0	57,000	57,000	0	57,000	-20,500	36,500
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,346	2,346	0	2,346	2,036	4,382
20. Fees, Subscriptions & Promotion	0	0	3,152	3,152	0	3,152	53	3,205
21. Clerical & General Office	0	269	2,371	2,640	0	2,640	5,855	8,495
22. Employee Benefits & Payroll	0	0	28,849	28,849	0	28,849	3,274	32,123
23. Inservice Training & Education	0	0	0	0	0	0	11	11
24. Travel and Seminar	0	0	0	0	0	0	5	5
25. Other Admin. Staff Trans	0	0	431	431	0	431	461	892
26. Insurance-Prop.Liab.Malpractice	0	0	5,906	5,906	0	5,906	65	5,971
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	269	100,055	100,324	0	100,324	-8,740	91,584
29. Total General Administrative	161,036	26,270	130,915	318,221	0	318,221	-10,446	307,775
30. Depreciation	0	0	21,873	21,873	0	21,873	1,476	23,349
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	1,174	1,174
32. Interest	0	0	16,917	16,917	0	16,917	1,520	18,437
33. Real Estate	0	0	5,285	5,285	0	5,285	30	5,315
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	4,615	4,615	0	4,615	105	4,720
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	48,690	48,690	0	48,690	4,305	52,995
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	28,280	28,280	0	28,280	0	28,280
43. Other (specify):*	0	9	3,102	3,111	0	3,111	-3,111	0
44. Total Special Cost Ce	0	9	31,382	31,391	0	31,391	-3,111	28,280
45. Grand Total	161,036	26,279	210,987	398,302	0	398,302	-9,252	389,050

		After
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	110,378	110,378
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	32,778	32,778
4. Supply Inventory	1,616	1,616
5. Short-Term Investments	0	0
6. Prepaid Insurance	5,056	5,056
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	285	285
10. Total current assets	150,113	150,113
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	10,000	10,000
14. Buildings, at Historical Cost	530,000	531,079
15. Leasehold Improvements, Historical Cost	6,845	6,944
16. Equipment, at Historical Cost	71,636	71,636
17. Accumulated Depreciation (book methods)	-298,838	-295,867
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	37,644	37,644
23. other (specify):	0	0
24. Total Long-Term Assets	357,287	361,436
25. Total Assets	507,400	511,549
CURRENT LIABILITIES		
26. Accounts Payable	4,051	4,051
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	10,524	10,524
31. Accrued Taxes Payable	3,941	3,941
32. Accrued Real Estate Taxes	5,364	5,364
33. Accrued Interest Payable	1,442	1,442
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,120	2,120
37. Other Current Liabilities (specify):	72,006	72,006
38. Total Current Liabilities	99,448	99,448
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	327,206	327,206
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	327,206	327,206
46.Total Liabilities	426,654	426,654
47.Total Equity	80,746	84,895
48.Total Liabilities and Equity	507,400	511,549

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	252,870
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	252,870
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	207
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	207
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	2,258
28. Other Revenue (specify):	79
Subtotal - Other Revenue	2,337
30. Total Revenue	255,414
31. General Services	59,270
32. Health Care	166,659
33. General Administration	110,011
34. Ownership	52,352
35. Special Cost Centers	4,416
35. Provider Participation Fee	28,634
37. Other	0
40. Total Expenses	421,342
41. Income Before Income Taxes	-165,928
42. Income Taxes	0
43. Net Income or Loss for the Year	-165,928