FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0005785

Facility Name: Resthave Home of Whiteside County

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: 05/22/69

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune, CPA **Telephone Number:** (779) 875 - 3979
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 09/01/17 to 08/31/18 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) Jill Smith
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Jeremy M. Brune, CPA, CEO
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	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	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,245	9,632	1,881	21,758	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,245	9,632	1,881	21,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.16%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/31/69

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 1,540

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 08/31/18 Fiscal Year: 08/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	278,665	23,540	5,893	308,098		308,098	(110,410)	197,688			1
2	Food Purchase		232,949		232,949		232,949	(86,613)	146,336			2
3	Housekeeping	213,146	27,773		240,919		240,919	(16,061)	224,858			3
4	Laundry		3,816		3,816		3,816	(548)	3,268			4
5	Heat and Other Utilities			165,799	165,799		165,799	(57,332)	108,467			5
6	Maintenance	78,190	15,912	91,288	185,390		185,390	(64,107)	121,283			6
7	Other (specify):* See Supplemental											7
8	**TOTAL General Services**	570,001	303,990	262,980	1,136,971		1,136,971	(335,072)	801,899			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,552,348	72,266	5,953	1,630,567		1,630,567	(246,847)	1,383,720			10
10a	Therapy											10a
11	Activities	108,326	7,347		115,673		115,673	(16,600)	99,073			11
12	Social Services	89,030	79	2,143	91,252		91,252	(13,095)	78,157			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	1,749,704	79,692	26,096	1,855,492		1,855,492	(276,543)	1,578,949			16
	C. General Administration											
17	Administrative	137,264		205,000	342,264		342,264	(76,390)	265,874			17
18	Directors Fees											18
19	Professional Services			134,399	134,399		134,399	(29,997)	104,402			19
20	Dues, Fees, Subscriptions & Promotions			27,692	27,692		27,692	(6,181)	21,511			20
21	Clerical & General Office Expenses	81,663	15,634	318,104	415,401		415,401	(326,404)	88,997			21
22	Employee Benefits & Payroll Taxes			383,921	383,921		383,921		383,921			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,894	1,894		1,894	(190)	1,704			24
25	Other Admin. Staff Transportation			3,661	3,661		3,661	(368)	3,293			25
26	Insurance-Prop.Liab.Malpractice			52,741	52,741		52,741	(11,771)	40,970			26
27	Other (specify):* See Supplemental											27
28	**TOTAL General Administration**	218,927	15,634	1,127,412	1,361,973		1,361,973	(451,301)	910,672			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,538,632	399,316	1,416,488	4,354,436		4,354,436	(1,062,915)	3,291,521			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Resthave Home of Whiteside County #0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			459,466	459,466		459,466	(158,881)	300,585			30
31	Amortization of Pre-Op. & Org.			1,316	1,316		1,316	(1,316)				31
32	Interest			653,688	653,688		653,688	(226,447)	427,241			32
33	Real Estate Taxes			85,158	85,158		85,158	(29,447)	55,711			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,835	7,835		7,835	(1,749)	6,086			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			1,207,463	1,207,463		1,207,463	(417,839)	789,624			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,421	280,364	323,785		323,785		323,785			39
40	Barber and Beauty Shops			21,176	21,176		21,176		21,176			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,989	161,989		161,989		161,989			42
43	Other (specify):* See Supplemental	45,262	7,344	47,695	100,301		100,301	(100,301)				43
44	**TOTAL Special Cost Centers**	45,262	50,765	511,224	607,251		607,251	(100,301)	506,950			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,583,894	450,081	3,135,175	6,169,150		6,169,150	(1,581,055)	4,588,095			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County
Medicaid Cost Report
09/01/17 - 08/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Marketing	45,262	7,344	47,695	100,301
				-
				-
				-
				-
				-
				-
Sub-Total	45,262	7,344	47,695	100,301

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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	(4,884)	02		4
5	Telephone, TV & Radio in Resident Rooms	(29,113)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(619)	32		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	(7,150)	21		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	(245,570)	21		24
25	Fund Raising, Advertising and Promotional				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 Supplemental	(1,293,719)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,581,055)		$	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))**	$ (1,581,055)		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

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County

ID# 0005785

Report Period Beginning: 09/01/17

Ending: 08/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (15,109)	21	1
2	Bank Charges	(2,031)	21	2
3	Flowers and Gifts	(1,860)	21	3
4	Amortization	(1,316)	31	4
5	Marketing	(100,301)	43	5
6				6
7	Non-Allowable (Assisted Living Allocations)			7
8				8
9	Dietary	(110,410)	1	9
10	Food	(81,729)	2	10
11	Housekeeping	(16,061)	3	11
12	Laundry	(548)	4	12
13	Heat and Other Utilities	(57,332)	5	13
14	Maintenance	(64,107)	6	14
15	Other	0	7	15
16	Medical Director	0	9	16
17	Nursing and Medical Records	(246,847)	10	17
18	Therapy	0	10a	18
19	Activities	(16,600)	11	19
20	Social Services	(13,095)	12	20
21	CNA Training	0	13	21
22	Transportation	0	14	22
23	Other	0	15	23
24	Administrative	(76,390)	17	24
25	Directors Fees	0	18	25
26	Professional Fees	(29,997)	19	26
27	Dues and Subscriptions	(6,181)	20	27
28	Office and Clerical	(25,571)	21	28
29	Employee Benefits	0	22	29
30	Inservice Training and Expense	0	23	30
31	Travel and Seminar	(190)	24	31
32	Other Staff Transportation	(368)	25	32
33	Insurance	(11,771)	26	33
34	Other	0	27	34
35	Depreciation	(158,881)	30	35
36	Amortization	0	31	36
37	Interest	(225,828)	32	37
38	Real Estate Taxes	(29,447)	33	38
39	Rent - Facilities and Grounds	0	34	39
40	Rent - Equipment and Vehicles	(1,749)	35	40
41	Other	0	36	41
42	Medically Necessary Transportation	0	38	42
43	Ancillary Service Centers	0	39	43
44	Barber and Beauty Shop	0	40	44
45	Coffee and Gift Shops	0	41	45
46	Provider Participation Fee	0	42	46
47	Other	0	43	47
48				48
49	**Total**	(1,293,719)		49

Resthave Home of Whiteside County
Medicaid Cost Report
09/01/17 - 08/31/18

Page 5 - Non-Care Supplemental Allocation Schedule

				Direct Nursing Home				Statistics		Expenses	
Desciption	Cost Center	Salary	Total Allow. Exp.	Salary	Other	Expenses For Alloc.	Alloc. Method	Nursing Home	Other	Nursing Home	Other
Dietary	1	278,665	308,098			308,098	Meals Served	65,274	36,456	197,688	110,410
Food	2	-	228,065			228,065	Meals Served	65,274	36,456	146,336	81,729
Housekeeping	3	213,146	240,919			240,919	SQFT (1)	16,558	1,183	224,858	16,061
Laundry	4	-	3,816			3,816	Pat. Days (1)	21,758	3,646	3,268	548
Heat and Other Utilities	5	-	165,799			165,799	SQFT	11,606	6,135	108,467	57,332
Maintenance	6	78,190	185,390			185,390	SQFT	11,606	6,135	121,283	64,107
Other	7	-	-			-	Pat. Days				
Medical Director	9	-	18,000			18,000	Dir. Staffing	18,000	-	18,000	-
Nursing and Medical Records	10	1,552,348	1,630,567			1,630,567	Dir. Staffing	1,299,129	231,757	1,383,720	246,847
Therapy	10a	-	-			-	Dir. Staffing				
Activities	11	108,326	115,673			115,673	Pat. Days (1)	21,758	3,646	99,073	16,600
Social Services	12	89,030	91,252			91,252	Pat. Days (1)	21,758	3,646	78,157	13,095
CNA Training	13	-	-			-	Dir. Staffing				
Transportation	14	-	-			-	Pat. Days				
Other	15	-	-			-	Pat. Days				
Administrative	17	137,264	342,264			342,264	Net. Pat. Rev.	4,096,865	1,177,103	265,874	76,390
Directors Fees	18	-	-			-	N/A				
Professional Fees	19	-	134,399			134,399	Net. Pat. Rev.	4,096,865	1,177,103	104,402	29,997
Dues and Subscriptions	20	-	27,692			27,692	Net. Pat. Rev.	4,096,865	1,177,103	21,511	6,181
Office and Clerical	21	81,663	114,568			114,568	Net. Pat. Rev.	4,096,865	1,177,103	88,997	25,571
Employee Benefits	22	-	383,921			383,921	Alloc. Salary	2,085,331	453,301	315,368	68,553
Inservice Training and Expense	23	-	-			-	Pat. Days				
Travel and Seminar	24	-	1,894			1,894	Pat. Days	21,758	2,430	1,704	190
Other Staff Transportation	25	-	3,661			3,661	Pat. Days	21,758	2,430	3,293	368
Insurance	26	-	52,741			52,741	Net. Pat. Rev.	4,096,865	1,177,103	40,970	11,771
Other	27	-	-			-	N/A				
Depreciation	30	-	459,466			459,466	SQFT	11,606	6,135	300,585	158,881
Amortization	31	-	-			-	Net. Pat. Rev.				
Interest	32	-	653,069			653,069	SQFT	11,606	6,135	427,241	225,828
Real Estate Taxes	33	-	85,158			85,158	SQFT	11,606	6,135	55,711	29,447
Rent - Facilities and Grounds	34	-	-			-	SQFT				
Rent - Equipment and Vehicles	35	-	7,835			7,835	Net. Pat. Rev.	4,096,865	1,177,103	6,086	1,749
Other	36	-	-			-	N/A				
Medically Necessary Transportation	38	-	-			-	N/A				
Ancillary Service Centers	39	-	323,785			323,785	Direct	323,785	-	323,785	-
Barber and Beauty Shop	40	-	21,176			21,176	Direct	21,176		21,176	-
Coffee and Gift Shops	41	-	-			-	Direct				
Provider Participation Fee	42	-	161,989			161,989	Direct	161,989	-	161,989	-
Other	43	45,262	-			-	Direct				
		2,583,894	5,761,197	-	-	5,761,197				4,519,542	1,241,655

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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	(110,410)	0	0	0	0	0	0	0	0	0	0	(110,410)	1
2	Food Purchase	(86,613)	0	0	0	0	0	0	0	0	0	0	(86,613)	2
3	Housekeeping	(16,061)	0	0	0	0	0	0	0	0	0	0	(16,061)	3
4	Laundry	(548)	0	0	0	0	0	0	0	0	0	0	(548)	4
5	Heat and Other Utilities	(57,332)	0	0	0	0	0	0	0	0	0	0	(57,332)	5
6	Maintenance	(64,107)	0	0	0	0	0	0	0	0	0	0	(64,107)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(335,072)	0	0	0	0	0	0	0	0	0	0	(335,072)	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	(246,847)	0	0	0	0	0	0	0	0	0	0	(246,847)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(16,600)	0	0	0	0	0	0	0	0	0	0	(16,600)	11
12	Social Services	(13,095)	0	0	0	0	0	0	0	0	0	0	(13,095)	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**	(276,543)	0	0	0	0	0	0	0	0	0	0	(276,543)	16
	C. General Administration													
17	Administrative	(76,390)	0	0	0	0	0	0	0	0	0	0	(76,390)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,997)	0	0	0	0	0	0	0	0	0	0	(29,997)	19
20	Fees, Subscriptions & Promotions	(6,181)	0	0	0	0	0	0	0	0	0	0	(6,181)	20
21	Clerical & General Office Expenses	(326,404)	0	0	0	0	0	0	0	0	0	0	(326,404)	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	(190)	0	0	0	0	0	0	0	0	0	0	(190)	24
25	Other Admin. Staff Transportation	(368)	0	0	0	0	0	0	0	0	0	0	(368)	25
26	Insurance-Prop.Liab.Malpractice	(11,771)	0	0	0	0	0	0	0	0	0	0	(11,771)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(451,301)	0	0	0	0	0	0	0	0	0	0	(451,301)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,062,915)	0	0	0	0	0	0	0	0	0	0	(1,062,915)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(158,881)	0	0	0	0	0	0	0	0	0	0	(158,881)	30
31	Amortization of Pre-Op. & Org.	(1,316)	0	0	0	0	0	0	0	0	0	0	(1,316)	31
32	Interest	(226,447)	0	0	0	0	0	0	0	0	0	0	(226,447)	32
33	Real Estate Taxes	(29,447)	0	0	0	0	0	0	0	0	0	0	(29,447)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,749)	0	0	0	0	0	0	0	0	0	0	(1,749)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(417,839)	0	0	0	0	0	0	0	0	0	0	(417,839)	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):*	(100,301)	0	0	0	0	0	0	0	0	0	0	(100,301)	43
44	**TOTAL Special Cost Centers**	(100,301)	0	0	0	0	0	0	0	0	0	0	(100,301)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,581,055)	0	0	0	0	0	0	0	0	0	0	(1,581,055)	45

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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								1
2	Board of Directors							2
3								3
4	Mary Beswick							4
5	Gretchen Bush							5
6	Tara Dykhulzen							6
7	Duane Habben							7
8	John Hauptman							8
9	Jerry Lindsey							9
10	Lester Mathew							10
11	Louise Thomas Parrish							11
12	Beth Polling							12
13	Susan Tegeler							13
14	Chick West							14
15	Marcia Haag							15
16	Martin Schuette							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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

VII. RELATED PARTIES (continued)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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 [X]

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

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

	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	USDA		X	Facility Expansion Project		05/18/16	$ 7,420,000	$ 7,693,571	05/18/55	3.50%	$ 368,116	1
2	Triumph Bank		X	Facility Expansion Project		09/21/16	4,680,000	4,783,013	09/21/55	5.23%	249,982	2
3												3
4												4
5												5
	Working Capital											
6	Triumph Bank		X	Line of Credit		08/21/16		620,941	08/21/19	5.25%	32,366	6
7	City of Morrison		X	Line of Credit		09/25/13	300,000	163,814	09/01/23	3.00%	3,223	7
8												8
9	TOTAL Facility Related						$ 12,400,000	$ 13,261,339			$ 653,687	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(619)	11
12	Non-Allowable - Asst. Liv.										(225,828)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (226,447)	14
15	TOTALS (line 9+line14)						$ 12,400,000	$ 13,261,339			$ 427,241	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	65,524	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.)	$	83,731	2
3. Under or (over) accrual (line 2 minus line 1).	$	18,207	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,505	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.	$	55,711	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014	63,903	9
2015	138,936	10
2016	83,136	11
2017	83,489	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

RE Tax Accrual = (83,489 * 1.03) / 12 * 8 = $57,329 * 65.42% = $37,505

NH Allocation = 65.42%

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.**

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resthave Home of Whiteside County COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (317) 574 - 9707

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09 - 17 - 352 - 015	Facility	$ 35,882.80	$ 35,882.80
2.	09 - 17 - 352 - 016	Facility	$ 47,605.54	$ 47,605.54
3.			$	$
4.		Non-Allowable Portion	$	$ (28,870.27)
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,488.34	$ 54,618.07

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? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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).

Assisted Living - 37 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	354,835		$ 10,977	1
2					2
3	TOTALS	354,835		$ 10,977	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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				1961	$ 140,758	$	30	$	$	$	4
5				1969	326,818		15 - 33				5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	6,242						9
10	Various			1976	2,320						10
11	Various			1980	1,681						11
12	Various			1981	1,039						12
13	Various			1982	127,530						13
14	Various			1983	14,116						14
15	Various			1984	22,779						15
16	Various			1985	3,880						16
17	Various			1986	2,698						17
18	Various			1987	2,623						18
19	Various			1988	14,500						19
20	Various			1989	14,220						20
21	Various			1993	208,977						21
22	Various			1996	9,670						22
23	Various			1997	9,260						23
24	Various			1998	2,751						24
25	Various			1999	27,294						25
26	Various			2001	67,722						26
27	Various			2002	335						27
28	Various			2003	49,191						28
29	Various			2004	44,691						29
30	Various			2010	19,280						30
31	Various			2011	2,346						31
32	Spouts and Repair Risers - Bury			2014	7,436						32
33	Generator			2015	302,535						33
34	Lift Station			2015	65,000						34
35	Excavation - Fisher Excavating			2015	333,979						35
36	Asphalt Paving - Fischer Excavating			2015	130,367						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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	Landscaping - Twin Oaks	2015	$ 39,350	$		$	$	$	37
38	Concrete - Northwest Commercial	2015	423,977						38
39	Masonry - Diamond Masonry	2015	62,600						39
40	General Trades - Lamp Incorporated	2015	1,976,033						40
41	Roofing - CPR Roofing, Inc.	2015	267,184						41
42	Drywall - NIWC	2015	695,874						42
43	Flooring - Rockford Carpetland	2015	323,822						43
44	Painting - All Tech Decorating	2015	103,080						44
45	Plumbing - Most Plumbing	2015	795,841						45
46	Fire Protection - Tristate Automatic Sprinkler	2015	284,644						46
47	HVAC - Heat Co Mechanical	2015	988,190						47
48	Electrical - Complete Electric	2015	961,263						48
49	Building - Phase 3	2015	5,059,576						49
50	Interest - Capitalized	2015	777,503						50
51	Building - Phase 2	2015	110,030						51
52	Soft Water Line to Mixing Valve	2016	2,352						52
53	Re-wire Basement Mechanical Room	2016	3,600						53
54	Medical Records & Dining Addition - Walls, Flooring, and Paint	2016	12,095						54
55	Accoustics - Dining Room	2017	8,802						55
56	Pump Motor	2017	10,344						56
57									57
58									58
59									59
60									60
61	Allocation - Assisted Living		(1,386,204)						61
62									62
63									63
64									64
65									65
66									66
67									67
68	Depreciation Expense			300,585		300,585		1,883,717	68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,481,994	$ 300,585		$ 300,585	$	$ 1,883,717	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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	$ 1,680,540	$	$	$		$	71
72	Current Year Purchases	12,264						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,692,804	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2012 Ford Van S2E	2012	$ 48,130	$	$	$		$	76
77	Maintenance	2001 Dodge Ram 1500	2014	5,500						77
78	Maintenance	Snow Plow Blade	2014	4,879						78
79										79
80	TOTALS			$ 58,509	$	$	$		$	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)	$	15,244,284	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	300,585	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	300,585	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,883,717	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	Assisted Living	$	$	$	86
87	Building & Improvements	1,386,204			87
88	Equipment	248,695			88
89	Depreciation		158,881	995,704	89
90					90
91	TOTALS	$ 1,634,899	$ 158,881	$ 995,704	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 6,086 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County
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Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Wells Fargo Financial Services	4,677	4,677
SBM Equiment Center	3,158	3,158
		-
		-
Non-Allowable: AL Allocations	(1,749)	(1,749)
		-
		-
		-
		-
		-
		-
		-
		-
Total	6,086	6,086

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 111,693	$		$ 111,693	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			20,734			20,734	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			137,794			137,794	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				43,421		43,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					0			12
13	Other (specify): See Supplemental	39 - 03				10,143			10,143	13
14	TOTAL			$		$ 280,364	$ 43,421		$ 323,785	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Laboratory / Radiology			10,143	10,143
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	10,143	10,143

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/18 (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	$ 500,172	$	1
2	Cash-Patient Deposits	4,871		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 230,000)	711,721		3
4	Supply Inventory (priced at)	8,062		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,608		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,227,434	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,477		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	14,537,255		15
16	Equipment, at Historical Cost	1,359,852		16
17	Accumulated Depreciation (book methods)	(2,879,421)		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): See Supplemental Schedule	45,311		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,074,474	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,301,908	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 415,116	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,871		28
29	Short-Term Notes Payable	620,941		29
30	Accrued Salaries Payable	152,718		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,329		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,250,975	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	163,814		39
40	Mortgage Payable	12,476,584		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,640,398	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,891,373	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 410,535	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,301,908	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Resthave Home of Whiteside County
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 23 - Long Term Assets			
Loan Fees (Net of Amortization)	45,311		45,311
			-
			-
			-
			-
Sub-Total	45,311	-	45,311
Line 36 - Other Current Liability			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,097,929	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,097,929	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(687,394)	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)**	$ (687,394)	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)**	$ 410,535	24	*

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,273,968	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,273,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	140,514	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 140,514	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	22,103	13
14	Non-Patient Meals	4,884	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)**	$ 26,987	23
	D. Non-Operating Revenue		
24	Contributions	24,559	24
25	Interest and Other Investment Income***	619	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,178	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	15,109	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,109	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,481,756	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,136,971	31
32	Health Care	1,855,492	32
33	General Administration	1,361,973	33
	B. Capital Expense		
34	Ownership	1,207,463	34
	C. Ancillary Expense		
35	Special Cost Centers	445,262	35
36	Provider Participation Fee	161,989	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,169,150	40
41	**Income before Income Taxes (line 30 minus line 40)****	(687,394)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (687,394)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,386,448	44
45	Private Pay - Net Inpatient Revenue	1,970,615	45
46	Medicare - Net Inpatient Revenue	717,620	46
47	Other-(specify) Insurance - Net Inpatient Revenue	22,182	47
48	Other-(specify) Private Pay - Assisted Living	1,177,103	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,273,968	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County
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Description		Amount		Total
Miscellaneous Income		15,109		15,109
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
				-
				-
Total		15,109		15,109

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,938	4,208	$ 132,690	$ 31.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,088	9,786	274,681	28.07	3
4	Licensed Practical Nurses	17,296	18,671	406,341	21.76	4
5	CNAs & Orderlies	56,926	61,006	720,772	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,104	37,521	17.83	9
10	Activity Assistants	6,676	7,119	70,805	9.95	10
11	Social Service Workers	5,460	5,845	89,030	15.23	11
12	Dietician					12
13	Food Service Supervisor	1,770	2,104	34,415	16.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,660	23,155	244,250	10.55	15
16	Dishwashers					16
17	Maintenance Workers	5,635	5,959	78,190	13.12	17
18	Housekeepers	18,712	20,137	213,146	10.58	18
19	Laundry					19
20	Administrator	1,880	2,104	67,193	31.94	20
21	Assistant Administrator					21
22	Other Administrative	1,275	1,659	70,071	42.24	22
23	Office Manager					23
24	Clerical	5,335	5,656	81,663	14.44	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	1,448	1,729	17,864	10.33	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,876	2,104	45,262	21.51	33
34	TOTAL (lines 1 - 33)	160,881	173,346	$ 2,583,894 *	$ 14.91	34

SEE ACCOUNTANTS' PREPARATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,893	01 - 03	35
36	Medical Director		18,000	19 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,605	10 - 03	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		2,143	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,641		49

C. CONTRACT NURSES

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

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

** See instructions.

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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Marketing	43	1,876	2,104	45,262	21.51		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		1,876	2,104	45,262	21.51		
Contracted Services							
Total						-	-

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tami Tegeler	Exec. Director	0	$ 70,071
Jill Smith	Administrator	0	67,193
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 137,264

B. Administrative - Other

Description	Amount
Jordan Healthcare Group, LLC	$ 205,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 205,000

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 37,779
Nelson, Kilgus, Richey & Buckwalter	Legal	510
Clifton Larson Allen, LLP	Audit, Tax & Cost Reports	35,618
Jeremy Brune & Assoc, LLC	Accounting	15,660
American Healthtech	Data Processing	16,348
Novatime	Data Processing	2,587
Ability Network	Data Processing	5,096
Clifton Larson Allen, LLp	IT Consulting	17,311
Other	Other	3,490
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 134,399

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,758
Unemployment Compensation Insurance	
FICA Taxes	199,044
Employee Health Insurance	132,085
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	1,846
Other Benefits - Net	(2,812)
TOTAL (agree to Schedule V, line 22, col.8)	$ 383,921

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	566
Health Care Worker Background Check	1,850
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	19,116
Licenses	4,170
Non-Allowable: AL Allocation	(6,181)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,894
Non-Allowable: AL Allocation	(190)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,704

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home of Whiteside County
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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Duane Morris	General Matters	02/28/18		9,236		9,236
Duane Morris	General Matters	03/31/18		8,548		8,548
Duane Morris	General Matters	04/30/18		13,768		13,768
Duane Morris	General Matters	05/31/18		6,228		6,228
Nelson, Kilgus, Richey & Buckwalter	General Matters	09/30/17		360		360
Nelson, Kilgus, Richey & Buckwalter	General Matters	09/30/17		150		150
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				38,289	-	38,289

Facility Name & ID Number Resthave Home of Whiteside County # 0005785 Report Period Beginning: 09/01/17 Ending: 08/31/18

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 = $6,646**

(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. $ **15,471** Line **10 - 02**

(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. $ **161,989**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **4,884**

(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? **Ln 14**
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: **Clifton Larson Allen (Not Finalized)**

(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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees