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: 0046896

Facility Name: White Hall Nursing and Rehabilitation Center, LLC

Address: 620 W Bridgeport Street (Number) White Hall (City) 62092 (Zip Code)

County: Greene

Telephone Number: (217) 374-2144 **Fax #** (217) 374-6714

HFS ID Number:

Date of Initial License for Current Owners: January 1, 2005

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Valerie M Gaydosh **Telephone Number:** (716) 972-2512
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 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) Valerie M Gaydosh
(Title) VP of Finance - Reimbursement for Tara Cares

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,235	7,687	7,845	38,767	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,235	7,687	7,845	38,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.25%

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)
Outpatient Therapy

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 5,609

Medicare Intermediary Wisconsin Physicians Insurance Corp (WPS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 1/1 to 12/31/18 Fiscal Year: 1/1 to 12/31/18

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Cente # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	246,347	28,696	27,047	302,090		302,090		302,090			1
2	Food Purchase		257,022		257,022		257,022	(2,486)	254,536			2
3	Housekeeping	163,582	20,404		183,986		183,986		183,986			3
4	Laundry	56,253	10,859		67,112		67,112		67,112			4
5	Heat and Other Utilities			106,994	106,994		106,994		106,994			5
6	Maintenance	60,727	39,796	52,625	153,148		153,148	(24,962)	128,186			6
7	Other (specify):* see trial balance			16,133	16,133		16,133		16,133			7
8	TOTAL General Services	526,909	356,777	202,799	1,086,485		1,086,485	(27,448)	1,059,037			8
	B. Health Care and Programs											
9	Medical Director			16,578	16,578		16,578		16,578			9
10	Nursing and Medical Records	2,467,076	172,701	27,271	2,667,048		2,667,048	(9,177)	2,657,871			10
10a	Therapy		4,610	1,019,876	1,024,486		1,024,486	(40,783)	983,703			10a
11	Activities	82,614	9,463	2,736	94,813		94,813		94,813			11
12	Social Services	91,928	370	2,016	94,314		94,314		94,314			12
13	CNA Training											13
14	Program Transportation			28,010	28,010		28,010	(6,485)	21,525			14
15	Other (specify):* see trial balance			17,231	17,231		17,231	(7,482)	9,749			15
16	TOTAL Health Care and Programs	2,641,618	187,144	1,113,718	3,942,480		3,942,480	(63,927)	3,878,553			16
	C. General Administration											
17	Administrative	242,678		261,228	503,906		503,906	(3,467)	500,439			17
18	Directors Fees											18
19	Professional Services			82,235	82,235		82,235	(6,720)	75,515			19
20	Dues, Fees, Subscriptions & Promotions			51,640	51,640		51,640	(35,840)	15,800			20
21	Clerical & General Office Expenses		70,038	151,564	221,602		221,602	(104,608)	116,994			21
22	Employee Benefits & Payroll Taxes			443,752	443,752		443,752	(139)	443,613			22
23	Inservice Training & Education											23
24	Travel and Seminar			27,299	27,299		27,299		27,299			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,868	65,868		65,868	(2,600)	63,268			26
27	Other (specify):* see trial balance			372,111	372,111		372,111	(210,208)	161,903			27
28	TOTAL General Administration	242,678	70,038	1,455,697	1,768,413		1,768,413	(363,582)	1,404,831			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,411,205	613,959	2,772,214	6,797,378		6,797,378	(454,957)	6,342,421			29

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC #0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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			215,048	215,048		215,048	41,647	256,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							255,805	255,805			32
33	Real Estate Taxes			164,891	164,891		164,891		164,891			33
34	Rent-Facility & Grounds			820,800	820,800		820,800	(820,800)				34
35	Rent-Equipment & Vehicles			50,133	50,133		50,133		50,133			35
36	Other (specify):* Off Site Storage			1,407	1,407		1,407		1,407			36
37	**TOTAL Ownership**			1,252,279	1,252,279		1,252,279	(523,348)	728,931			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			266,871	266,871		266,871		266,871			42
43	Other (specify):* see trial balance			431,127	431,127		431,127	(87,718)	343,409			43
44	**TOTAL Special Cost Centers**			697,998	697,998		697,998	(87,718)	610,280			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,411,205	613,959	4,722,491	8,747,655		8,747,655	(1,066,023)	7,681,632			45

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(2,246)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(3)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(240)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(84,087)	21		18
19	Entertainment				19
20	Contributions	(300)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(356,064)	27		24
25	Fund Raising, Advertising and Promotional	(31,607)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(350,043)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (824,590)		$	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)	(241,433)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (241,433)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,066,023)		37

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

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

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

White Hall Nursing and Rehabilitation Center, LLC

ID# 0046896

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Remove Non-allowable Admin Dues& Subscriptions	$ (2,503)	20	1
2	Remove Non-allowable Admiss Dues& Subscriptions	(135)	20	2
3	Remove Non-allowable Admissions Other Supplies	(13,516)	21	3
4	Remove Non-allowable Insurance Cost	(2,600)	26	4
5	Remove Non-allowable Admin Other Supplies	(1,803)	21	5
6	Remove Non-allowable NRS Admin-Purchased Svcs	(1,022)	15	6
7	Remove Non-allowable Finance Charges	(871)	21	7
8	Remove Non-allow Admin-TaxCreditSvcs(WOTC)	(2,513)	21	8
9	Remove Non-allowable NRS Admin-Res Transport	(6,485)	14	9
10	Remove Non-allowable HR-EE background checks	(1,595)	20	10
11	Remove Non-allowable BO Tax Preperation Fees	(3,245)	19	11
12	Remove Non-allow Outpatient Svcs-Consol Billing	(46)	43	12
13	Remove Non-allowable IV Rx Drugs Costs	(35,341)	43	13
14	Remove Non-allowable Prior Year Costs	(21,284)	43	14
15	Offset Misc. Revenue Med Surgical	(1,553)	10	15
16	Offset Misc. Revenue Food Supplies	(58)	10	16
17	Offset Misc. Revenue Non-Med Equipment	(79)	6	17
18	Offset Misc. Revenue Incontient Supplies	(910)	10	18
19	Offset Misc. Revenue Equipment	(9)	10	19
20	Offset Misc. Revenue Other	(14)	21	20
21	Capitalize repairs & Maintenance & Equipment	(2,805)	10	21
22	Capitalize repairs & Maintenance & Equipment	(24,326)	6	22
23	Depreciation/Amort LHI	5,646	30	23
24	Depreciation/Amort MME	10,369	30	24
25	Current Year Depreciation Audit Adjustments LHI	(1,604)	30	25
26	Offset Outpatient Physical Therapy Revenue	(215,240)	10a	26
27	Offset Outpatient Occupational Therapy Revenue	(12,076)	10a	27
28	Offset Outpatient Speech Therapy Revenue	(9,736)	10a	28
29	Remove Non-allowable Admin Legal Fees	(3,475)	19	29
30	Offset Interco Sold Services Revenue	(557)	6	30
31	Offset Interco Sold Services Revenue	(501)	10	31
32	Offset Interco Sold Services Revenue	(156)	22	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**	(350,043)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,486)	0	0	0	0	0	0	0	0	0	0	(2,486)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(24,962)	0	0	0	0	0	0	0	0	0	0	(24,962)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(27,448)	0	0	0	0	0	0	0	0	0	0	(27,448)	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	(5,836)	(3,341)	0	0	0	0	0	0	0	0	0	(9,177)	10
10a	Therapy	(237,052)	196,269	0	0	0	0	0	0	0	0	0	(40,783)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(6,485)	0	0	0	0	0	0	0	0	0	0	(6,485)	14
15	Other (specify):*	(1,022)	(6,460)	0	0	0	0	0	0	0	0	0	(7,482)	15
16	**TOTAL Health Care and Programs**	(250,395)	186,468	0	0	0	0	0	0	0	0	0	(63,927)	16
	C. General Administration													
17	Administrative	0	(3,467)	0	0	0	0	0	0	0	0	0	(3,467)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,720)	0	0	0	0	0	0	0	0	0	0	(6,720)	19
20	Fees, Subscriptions & Promotions	(35,840)	0	0	0	0	0	0	0	0	0	0	(35,840)	20
21	Clerical & General Office Expenses	(102,807)	(1,801)	0	0	0	0	0	0	0	0	0	(104,608)	21
22	Employee Benefits & Payroll Taxes	(156)	17	0	0	0	0	0	0	0	0	0	(139)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	26
27	Other (specify):*	(356,364)	0	146,156	0	0	0	0	0	0	0	0	(210,208)	27
28	**TOTAL General Administration**	(504,487)	(5,251)	146,156	0	0	0	0	0	0	0	0	(363,582)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(782,330)	181,217	146,156	0	0	0	0	0	0	0	0	(454,957)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	14,411	0	27,236	0	0	0	0	0	0	0	0	41,647	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	255,805	0	0	0	0	0	0	0	0	255,805	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(820,800)	0	0	0	0	0	0	0	0	(820,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	14,411	0	(537,759)	0	0	0	0	0	0	0	0	(523,348)	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):*	(56,671)	(31,047)	0	0	0	0	0	0	0	0	0	(87,718)	43
44	TOTAL Special Cost Centers	(56,671)	(31,047)	0	0	0	0	0	0	0	0	0	(87,718)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(824,590)	150,170	(391,603)	0	0	0	0	0	0	0	0	(1,066,023)	45

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DTD HC, LLC	50%	Granite Nursing and Rehabilitation Center, LLC	Granite City	Tara Pharmacy SE, LI	Birmingham	Pharmacy
D & N, LLC	50%	Stearns Nursing and Rehabilitation Center, LLC	Granite City	Tara Therapy, LLC	Orchard Park	Therapy
		Calhoun Nursing and Rehabilitation Center, LLC	Hardin	Raimax Healthcare So	Orchard Park	Software
		Scenic Nursing and Rehabilitation Center, LLC	Herculaneum	White Hall Property C	White Hall	Property Company
		Jefferson City Nursing & Rehabilitation Center, LLC	Jefferson City	3690 N. H. Associates,	Orchard Park	Clearing Account
		Riverside Nursing and Rehabilitation Center, LLC	Kansas City	Health Care Risk Grou	Orchard Park	Insurance
		Douglasville Nursing & Rehabilitation Center, LLC	Douglasville	Aurora Cares, LLC d/l	Orchard Park	Support Office

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Services Costs	$ 261,228	Aurora Cares, LLC d/b/a Tara Cares	0.00%	$ 257,761	$ (3,467)	1
2	V	15	Wireless Access Points License Fee	3,933	RAImax Healthcare Solutions Group, LLC	0.00%	659	(3,274)	2
3	V	15	Patient Care Software	3,600	RAImax Healthcare Solutions Group, LLC	0.00%	414	(3,186)	3
4	V	21	Carrier Comm Rev Offset		RAImax Healthcare Solutions Group, LLC	0.00%	(1,801)	(1,801)	4
5	V	10	Pharmacy Consulting Services	25,704	Tara Pharmacy SE, LLC	0.00%	22,363	(3,341)	5
6	V	43	Flu Vac/Prescription Drug- Residents	324,646	Tara Pharmacy SE, LLC	0.00%	293,599	(31,047)	6
7	V	22	Vaccines for Employees	1,817	Tara Pharmacy SE, LLC	0.00%	1,834	17	7
8	V	10a	Physical Therapy Fees	519,051	Tara Therapy, LLC	0.00%	640,679	121,628	8
9	V	10a	Occupational Therapy Fees	370,826	Tara Therapy, LLC	0.00%	383,974	13,148	9
10	V	10a	Speech Therapy Fees	129,999	Tara Therapy, LLC	0.00%	191,492	61,493	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,640,804			$ 1,790,974	$ * 150,170	14

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent	$ 820,800	White Hall Property Company, LLC	0.00%	$	$ (820,800)	15
16	V	30	Depreciation Leasehold Imp		White Hall Property Company, LLC	0.00%	16,450	16,450	16
17	V	30	Depreciation Major Moveable		White Hall Property Company, LLC	0.00%	4,860	4,860	17
18	V	30	Depreciation Bldg & Improve		White Hall Property Company, LLC	0.00%	5,926	5,926	18
19	V	27	Amort Loan Acquisition Costs		White Hall Property Company, LLC	0.00%	146,156	146,156	19
20	V	32	Interest -Capital/Long-Term Debt		White Hall Property Company, LLC	0.00%	254,384	254,384	20
21	V	32	Interest - SWAP		White Hall Property Company, LLC	0.00%	1,421	1,421	21
22	V	1	Dietary Service	20,407	Scenic Nursing and Rehabilitation Center, LLC	0.00%	20,407		22
23	V	1	Dietary Service	5,140	Stearns Nursing and Rehabilitation Center, LLC	0.00%	5,140		23
24	V	10	Nursing Service	1,566	Calhoun Nursing and Rehabilitation Center, LLC	0.00%	1,566		24
25	V								25
26	V								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			$ 847,913			$ 456,310	$ * (391,603)	39

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Cent # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	DTD HC, LLC	Owner		50.00		0	0.00		$ 0	17	1
2	D & N, LLC	Owner		50.00		0	0.00		0	17	2
3	Donald T. Denz	CFO & CoCEO	Finance/ Admin	0.00	***	0.8	2.00	Fin/ Adm. of TC	6,390	17	3
4		for Tara Cares	of Tara Cares								4
5	Norbert A. Bennett	CoCEO	Finance/ Admin	0.00	***	0.8	2.00	Fin/ Adm. of TC	6,390	17	5
6		for Tara Cares	of Tara Cares								6
7	Suzette Wilson	Vice President	Admin	0.00	***	0.8	2.00	VP of TC	4,854	17	7
8			of Tara Cares								8
9											9
10	*** Compensation paid only through Support Office and allocated share reported in column 7.										10
11											11
12											12
13								TOTAL	$ 17,634		13

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Aurora Cares, LLC d/b/a Tara Cares
Street Address: PO Box 428
City / State / Zip Code: Orchard Park, NY 14127
Phone Number: (716)662-4955
Fax Number: (716)662-2529

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Administrative Services Costs	Total Costs	410,302,287	40	$ 363,526	$ 281,911	8,461,491	$ 7,495	1
2	5	Administrative Services Costs	Days	1,573,455	36	31,735	0	38,753	782	2
3	6	Administrative Services Costs	Days	1,573,455	36	103,375	0	38,753	2,545	3
4	10	Administrative Services Costs	Total Costs	410,302,287	40	2,503,148	1,991,472	8,461,491	51,633	4
5	17	Administrative Services Costs	Days	1,573,455	36	6,190,204	6,190,204	38,753	152,459	5
6	19	Administrative Services Costs	Days	1,573,455	36	18,129	0	38,753	447	6
7	20	Administrative Services Costs	Days	1,573,455	36	59,441	0	38,753	1,464	7
8	21	Administrative Services Costs	Days	1,573,455	36	397,184	0	38,753	9,782	8
9	22	Administrative Services Costs	Days	1,573,455	36	858,888	0	38,753	21,152	9
10	24	Administrative Services Costs	Days	1,573,455	36	131,312	0	38,753	3,235	10
11	26	Administrative Services Costs	Days	1,573,455	36	5,953	0	38,753	146	11
12	27	Administrative Services Costs	Days	1,573,455	36	89,725	0	38,753	2,211	12
13	30	Administrative Services Costs	Days	1,573,455	36	62,915	0	38,753	1,549	13
14	31	Administrative Services Costs	Days	1,573,455	36	4,349	0	38,753	107	14
15	33	Administrative Services Costs	Days	1,573,455	36	32,625	0	38,753	804	15
16	34	Administrative Services Costs	Days	1,573,455	36	77,325	0	38,753	1,904	16
17	35	Administrative Services Costs	Days	1,573,455	36	1,849	0	38,753	46	17
18										18
19										19
20		NOTE: Aurora Cares, LLC d/b/a Tara Cares provides administrative support services under contract to the reporting facility.								20
21		Aurora Cares, LLC has no ownership interest and does not manage the reporting faciltiy. Therefore, Aurora Cares, LLC is not								21
22		considered a Home Office by CMS and as defined in 42CFR 421.404.								22
23										23
24										24
25	TOTALS					$ 10,931,683	$ 8,463,587		$ 257,761	25

Facility Name & ID Number White Hall Nursing and Rehabilitation Cente # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Key Bank		X	Land and Building	$27,885.00	02/28/14	$ 6,368,179	$	08/30/18	Libor Plus	$ 124,948	1
2	Key Bank		X	Land and Building	$11,318.00	02/28/14	2,706,821		08/30/18	Libor Plus 2%	44,761	2
3	M & T Bank		X	Land and Building	$19,384.44	08/30/18	4,335,000	4,262,715	09/01/23	Libor Plus 2%	86,095	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$58,587.44		$ 13,410,000	$ 4,262,715			$ 255,804	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 13,410,000	$ 4,262,715			$ 255,804	15

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

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.**	$ 171,000	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.)		$ 163,847	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,153)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 172,044	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.		$ 164,891	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	79,245	8
	2014	75,398	9
	2015	75,672	10
	2016	162,943	11
	2017	163,847	12

The 2018 assessment was estimated to be a 5% increase over the 2017 assessment.

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

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME White Hall Nursing and Rehabilitation Center, LLC COUNTY Greene

FACILITY IDPH LICENSE NUMBER 0046896

CONTACT PERSON REGARDING THIS REPORT Valerie M. Gaydosh

TELEPHONE (716) 662-4955, ext 512 FAX #: (716) 662-2529

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.	11-53-34-400-002	620 W. Bridgeport Street	$ 163,846.72	$ 163,846.72
2.		3W JC 536	$	$
3.		34-12-12	$	$
4.		PT N MID PT E1/2 SE	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 163,846.72	$ 163,846.72

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 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 White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 63,995
2. Number of Years Over Which it is Being Amortized: 5 years (60 months)
3. Current Period Amortization: Included in Schedule VII B Ln 1, Col 7
4. Dates Incurred: Various and on the books of related entities

Nature of Costs: Inc. Capitalized Pre-opening Salaries, Benefits&Other Costs Incurred. Allocated via Related Org Cost & Reported Sch VII B
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	209,829	2011	$ 19,707	1
2					2
3	TOTALS	209,829		$ 19,707	3

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		2011	1972	$ 237,024	$ 5,925	40	$ 5,925	$	$ 44,442	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alumalite Sign			2005	797		10			797	9
10	Generator Repairs, capitalized for Medicaid			2005	2,270		3			2,270	10
11	Auto Cad Design for Fire Alarm System			2006	1,080		10			1,080	11
12	Sign Pillars w/ Lighting			2006	8,975		10			8,975	12
13	Window Treatment			2006	13,663		10			13,663	13
14	Shower Room Renovations			2006	46,015	1,917	12	1,917		46,015	14
15	Measure & Install Blinds in Facility			2006	10,998		5			10,998	15
16	Handrail and Background Staining			2006	14,880	620	12	620		14,880	16
17	Electrical Wiring (lighting & smoke detectors)			2006	23,000	958	12	958		23,000	17
18	Sprinkler System Repairs, capitalized for Medicaid			2006	3,194		3			3,194	18
19	Installation of Data Outlet Recepticles for Medicaid			2007	4,160		3			4,160	19
20	Dry Wall - Entire Building			2007	10,329		10			10,329	20
21	3 Electric Water Heaters			2007	2,534		10			2,534	21
22	Phone System	REDUCED ON AUDIT		2007	10,021	502	10	502		10,021	22
23	Dish Machine	REDUCED ON AUDIT		2007	4,000	200	10	200		4,000	23
24	Smoke Detectors			2008	3,125	156	10	156		3,125	24
25	Window replacement (windows, sills, trim)			2009	40,527	2,252	9	2,252		40,527	25
26	Nurse Station			2009	56,951	3,164	9	3,164		56,951	26
27	Tile Floor			2009	13,887	771	9	771		13,887	27
28	A/C Roof Unit Repair - capitalized for Medicaid			2009	2,948		3			2,948	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	A/C Units (4)	2010	$ 2,099	$	5	$	$	$ 2,099	37
38	A/C Units (3)	2010	1,626	102	8	102		1,626	38
39	Walk-In Freezer	2010	12,075	755	8	755		12,075	39
40	RepairsFromLightningStrike-capMcdREDUCED ON AUDIT	2010	8,790		3			8,790	40
41	Water Softener System	2011	4,233	302	7	302		4,233	41
42	A/C Unit (5)	2011	2,688		5			2,688	42
43	Window Replacement	2011	47,741	3,410	7	3,410		47,741	43
44	Parking Lot Repairs capitalized for Medicaid	2011	2,600		3			2,600	44
45	A/C Units (4)	2012	2,372		5			2,372	45
46	Air Curtain	2012	721	48	15	48		312	46
47	Built-in AC Units (2)	2012	1,186		5			1,186	47
48	5-Ton AC Unit	2013	3,929	262	15	262		1,440	48
49	2 Built in AC Units	2013	1,258	126	5	126		1,258	49
50	Cabling - Wireless Upgrade	2013	3,539	177	20	177		973	50
51	Replaced Floor Tile in Dining Room and North Lounge	2013	17,016	1,702	10	1,702		9,359	51
52									52
53	AC Units - Built in (2)	2013	1,258	126	5	126		1,258	53
54	Flooring for Behavior Memory Unit	2014	29,355	2,935	10	2,935		13,210	54
55	A/C Unit 8.5 Ton Rooftop	2014	9,837	984	10	984		4,427	55
56	AC Units - Built in (18)	2014	12,680	2,536	5	2,536		11,412	56
57	AC Units - Built in (4)	2014	2,593	519	5	519		2,335	57
58	Smoker's Gazebo (1)	2014	2,693	269	10	269		1,211	58
59	18 Bed / Therapy Expansion - IDPH # L3619	2015	3,760,340	150,413	25	150,413		526,448	59
60	Replace 1,000 sq feet of asphalt pavement- capitalized for Medicai	2015	3,981	498	8	498		1,741	60
61	Labor and Materials to rebuild concrete pad for dumpster - Cap f	2016	2,975	198	15	198		496	61
62	Landscaping and planting flowers	2017	2,913	291	10	291		437	62
63	Gym Entry Door capitalized for Medicaid	2018	3,964	99	20	99		99	63
64	Generator Repairs capitalized for Medicaid	2018	11,046	1,105	5	1,105		1,105	64
65	Fire Alarm capitalized for Medicaid	2018	2,617	131	10	131		131	65
66									66
67	Note: See additional building improvements made by former		626,406	12,627		12,627		605,224	67
68	property owner Healthcare REIT, Inc. on supplemental								68
69	schedule included as page 23 of the cost report.								69
70	TOTAL (lines 4 thru 69)		$ 5,094,909	$ 196,080		$ 196,080	$	$ 1,586,082	70

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 387,804	$ 66,865	$ 66,865	$	Various	$ 243,543	71
72	Current Year Purchases	9,504	768	768		Various	768	72
73	Fully Depreciated Assets	265,584	5,609	5,609		Various	265,584	73
74								74
75	TOTALS	$ 662,892	$ 73,242	$ 73,242	$		$ 509,895	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,814,183	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,322	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 269,322	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,132,652	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 53,356 Description: see separate schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									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 White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 30,253	$	1
2	Cash-Patient Deposits	15,740		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,016,167		3
4	Supply Inventory (priced at cost)	10,308		4
5	Short-Term Investments			5
6	Prepaid Insurance	6,344		6
7	Other Prepaid Expenses	2,854		7
8	Accounts Receivable (owners or related parties)	(390,905)		8
9	Other(specify): Non Resident A/R (see TB)	23,469		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 714,230	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,833,611		15
16	Equipment, at Historical Cost	381,445		16
17	Accumulated Depreciation (book methods)	(834,250)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(5,316)		21
22	Other Long-Term Assets (spe Deposits Long Term	1,758		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,377,248	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,091,478	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,037	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,692		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	363,473		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,797		31
32	Accrued Real Estate Taxes(Sch.IX-B)	172,044		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits Payable	31,605		36
37	Accrued Expenses	242,265		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,094,913	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,094,913	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,996,565	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,091,478	$	48

*(See instructions.)

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,160,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,160,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(453,675)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	290,000	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)**	$ (163,675)	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)**	$ 2,996,565	24 *

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 6,523,645	1
2	Discounts and Allowances for all Levels	752,748	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,276,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	237,052	5
6	Therapy	734,364	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 971,416	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	2,246	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,949	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	137	19
20	Radiology and X-Ray	157	20
21	Other Medical Services	1,154	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,643	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,184	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,184	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Prior Year Net Revenue**	24,262	28
28a	**Purchase Discounts & Misc Revenue**	4,082	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,344	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,293,980	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,086,485	31
32	Health Care	3,942,480	32
33	General Administration	1,768,413	33
	B. Capital Expense		
34	Ownership	1,252,279	34
	C. Ancillary Expense		
35	Special Cost Centers	431,127	35
36	Provider Participation Fee	266,871	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,747,655	40
41	**Income before Income Taxes (line 30 minus line 40)****	(453,675)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (453,675)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,995,470	44
45	Private Pay - Net Inpatient Revenue	1,209,266	45
46	Medicare - Net Inpatient Revenue	2,592,290	46
47	Other-(specify) **Hospice**	174,580	47
48	Other-(specify) **Medicare HMO**	304,787	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,276,393	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** see Pg 19 note **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,150	$ 80,937	$ 37.65	1
2	Assistant Director of Nursing	224	240	4,596	19.15	2
3	Registered Nurses	13,176	13,656	447,164	32.74	3
4	Licensed Practical Nurses	28,998	31,000	785,790	25.35	4
5	CNAs & Orderlies	76,010	81,837	1,090,993	13.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,828	2,068	32,559	15.74	9
10	Activity Assistants	4,343	4,591	50,055	10.90	10
11	Social Service Workers	5,283	6,234	91,928	14.75	11
12	Dietician					12
13	Food Service Supervisor	1,024	1,276	16,553	12.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,740	5,613	53,736	9.57	15
16	Dishwashers	16,507	18,462	176,058	9.54	16
17	Maintenance Workers	3,748	4,116	60,727	14.75	17
18	Housekeepers	14,300	15,816	163,582	10.34	18
19	Laundry	5,326	5,870	56,253	9.58	19
20	Administrator	1,872	2,080	79,421	38.18	20
21	Assistant Administrator					21
22	Other Administrative	3,805	4,200	88,207	21.00	22
23	Office Manager	1,867	2,073	40,425	19.50	23
24	Clerical	2,497	2,633	34,625	13.15	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	2,907	3,321	51,913	15.63	31
32	Other Health Care(specify)					32
33	Other(specify) Central Supply	447	447	5,683	12.71	33
34	TOTAL (lines 1 - 33)	190,822	207,683	$ 3,411,205 *	$ 16.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	257	16,578	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	232	25,704	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,736	11-3	44
45	Social Service Consultant	33	2,016	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	551	$ 46,034		49

C. CONTRACT NURSES

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christine Warcup	Administrator	0	$ 79,421
Leah Henson	Bus. Office Mgr	0	40,425
Kim Schutz	Bus. Office Ast	0	27,373
Melissa Nichols	Bus. Office Ast	0	7,252
Nancy Willenburg	HR/Payroll	0	40,789
Brian Elliot	Admiss Director	0	47,418
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 242,678

B. Administrative - Other

Description	Amount
Tara Cares Administrative Services Fee	$ 261,228
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 261,228

C. Professional Services

Vendor/Payee	Type	Amount
Freed, Maxick & Battaglia	Accounting Fees	$ 2,568
Freed, Maxick & Battaglia	Tax Fees	3,245
Various Legal Fees - See attached detailed listing		76,422
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 82,235

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,251
Unemployment Compensation Insurance	18,277
FICA Taxes	252,419
Employee Health Insurance	64,604
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Worker Compensation Saftey Rec. Program	7,938
Employee Benefit - Holiday/Recognition	10,209
Employee Benefit - Short Term Disability	393
Employee Benefit - Employee Vaccinations	1,834
Employee Benefit - H.S.A ER/Tuition Reimb	8,235
Employee Benefit - Life Insurance (ER)	118
Employee Benefit - Dental/Vision Ins (ER)	2,335
TOTAL (agree to Schedule V, line 22, col.8)	$ 443,613

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

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

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,993
Advertising: Employee Recruitment	5,934
Health Care Worker Background Check	126
(Indicate # of checks performed 9)	
Patient Background Checks 67	670
Facility Advertising	31,607
IL. Health Care Association/Chamber/Econ	7,989
Non-allwHealthCareAssn/ChamberC	(2,638)
Fingerprinting	280
Citrix License Renew	1,446
Less: Public Relations Expense	( )
Non-allowable advertising	(31,607)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,800

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	27,299
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,299

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 $5,351 net of non-allowables**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,178** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **266,871**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,246**

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

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

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

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

Facility Name & ID Number White Hall Nursing and Rehabilitation Center, LLC # 0046896 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements Made by Health Care REIT (covered by rent at outset										9
10	of Change of Ownership):										10
11											11
12	Ductwork			2005	65,173	3,259	20	3,259		43,991	12
13	EPDM Roof System			2005	213,004		10			213,004	13
14	Fire Alarm System			2005	30,608		10			30,608	14
15	Service Doors (2), Break Room Door (1)			2005	4,650	178	13	178		4,650	15
16	Drywall seven (7) rooms			2005	1,983	76	13	76		1,983	16
17	A/C Units			2006	18,611		5			18,611	17
18	Installation of Fire Alarm System			2006	1,820		10			1,820	18
19	Chair Rails			2006	2,380	99	12	99		2,380	19
20	Paint Ceilings in Resident Rooms			2006	3,825		5			3,825	20
21	Wall Repair and Painting of Facility			2006	55,141		5			55,141	21
22	A/C Unit 5 Ton			2006	3,600		10			3,600	22
23	Landscaping			2006	9,979		10			9,979	23
24	Sprinkler System			2006	169,310	7,055	12	7,055		169,310	24
25	Suspend Ceiling			2006	46,322	1,960	12	1,960		46,322	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36					626,406	12,627		12,627		605,224	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

XVII. INCOME STATEMENT Page 19 Note

Line 41 Income before Income Taxes (453,675) **
Does this agree with taxable income(loss) per Federal Income Tax Return?

** The Tax Return has been extended with a due date after the cost report filing date. It is expected that the cost report income and tax return income will agree.