FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Whiteside Co

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
	Corporation	Other
	"Sub-S" Corp.	
	Limited Liability Co.	
	Trust	
	Other	

IRS Exemption Code 501(c)(3)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/19 to 08/31/20 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, Chief Executive Officer
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune, CPA Telephone Number: (779) 875 - 3979
Email Address:

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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	25,620	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,620	7

B. Census-For the entire report period.

	1 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	9,736	10,593	2,475	22,804	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,736	10,593	2,475	22,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.01%

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 1,732

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 08/31/20 Fiscal Year: 08/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	308,545	21,591	7,216	337,352		337,352	(122,434)	214,918			1
2	Food Purchase		244,772		244,772		244,772	(90,137)	154,635			2
3	Housekeeping	247,948	39,882	873	288,704		288,704	(51,175)	237,529			3
4	Laundry		10,346		10,346		10,346	(1,834)	8,512			4
5	Heat and Other Utilities			200,162	200,162		200,162	(117,074)	83,088			5
6	Maintenance	86,907	17,026	104,470	208,403		208,403	(102,987)	105,416			6
7	Other (specify):* See Supplemental											7
8	**TOTAL General Services**	643,400	333,617	312,721	1,289,738		1,289,738	(485,640)	804,098			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,415,828	89,606	5,535	1,510,970		1,510,970	(14,131)	1,496,839			10
10a	Therapy											10a
11	Activities	114,070	6,349	2,349	122,768		122,768	(17,185)	105,583			11
12	Social Services	86,133	224		86,357		86,357	0	86,357			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	1,616,031	96,179	25,885	1,738,094		1,738,094	(31,315)	1,706,779			16
	C. General Administration											
17	Administrative	76,546		240,000	316,546		316,546	(59,310)	257,236			17
18	Directors Fees											18
19	Professional Services			198,222	198,222		198,222	(60,019)	138,203			19
20	Dues, Fees, Subscriptions & Promotions			15,596	15,596		15,596	(3,895)	11,701			20
21	Clerical & General Office Expenses	108,071	18,667	79,887	206,625		206,625	(103,079)	103,546			21
22	Employee Benefits & Payroll Taxes			401,600	401,600		401,600		401,600			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,061	3,061		3,061	(756)	2,304			24
25	Other Admin. Staff Transportation			4,710	4,710		4,710	(1,164)	3,546			25
26	Insurance-Prop.Liab.Malpractice			58,136	58,136		58,136	(14,367)	43,770			26
27	Other (specify):* See Supplemental											27
28	**TOTAL General Administration**	184,617	18,667	1,001,211	1,204,496		1,204,496	(242,589)	961,906			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,444,047	448,464	1,339,817	4,232,328		4,232,328	(759,545)	3,472,783			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 Whiteside Co #0005785 **Report Period Beginning:** 09/01/19 **Ending:** 08/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			442,772	442,772		442,772	(218,574)	224,198			30
31	Amortization of Pre-Op. & Org.			1,224	1,224		1,224	(1,224)	0			31
32	Interest			342,686	342,686		342,686	(170,098)	172,588			32
33	Real Estate Taxes			105,243	105,243		105,243	(51,953)	53,290			33
34	Rent-Facility & Grounds			1,860	1,860		1,860	(918)	942			34
35	Rent-Equipment & Vehicles			13,964	13,964		13,964	(3,451)	10,513			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			907,750	907,750		907,750	(446,218)	461,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,825	295,293	386,118		386,118		386,118			39
40	Barber and Beauty Shops			13,165	13,165		13,165		13,165			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,476	166,476		166,476		166,476			42
43	Other (specify):* See Supplemental	334,282	12,285	47,354	393,921		393,921	(393,921)				43
44	**TOTAL Special Cost Centers**	334,282	103,110	522,287	959,680		959,680	(393,921)	565,758			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,778,330	551,574	2,769,854	6,099,757		6,099,757	(1,599,685)	4,500,073			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 Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 4 Supplemental Schedule

Line 36 - Other Capital Costs

Description	Salaries	Supplies	Other	Total
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Line 43 - Other Special Cost Centers

Description	Salaries	Supplies	Other	Total
Assisted Living	287,106			287,106
Marketing	47,176	12,285	47,354	106,815
				-
				-
				-
				-
				-
Sub-Total	334,282	12,285	47,354	393,921

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	(2,044)	02		4
5	Telephone, TV & Radio in Resident Rooms	(36,071)	05		5
6	Rented Facility Space	(215)	06		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	(1,840)	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				18
19	Entertainment				19
20	Contributions	(54)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,758)	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	(1,490,703)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,599,685)		$	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))**	$ (1,599,685)		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 Whiteside Co

ID# 0005785

Report Period Beginning: 09/01/19

Ending: 08/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Fees (See Page 21 Sub-Schedule)	$ (4,250)	19	1
2	Collections	(10,405)	19	2
3	Bank Charges	(333)	21	3
4	Loan Amortization	(1,224)	31	4
5				5
6	Assisted Living Allocations			6
7	Dietary	(122,434)	01	7
8	Food	(88,093)	02	8
9	Housekeeping	(51,175)	03	9
10	Laundry	(1,834)	04	10
11	Heat & Other Utilities	(81,003)	05	11
12	Maintenance	(102,772)	06	12
13	Other	0	07	13
14	Medical Director	0	09	14
15	Nursing & Medical Records	(14,131)	10	15
16	Therapy	0	10a	16
17	Activities	(17,185)	11	17
18	Social Services	0	12	18
19	CNA Training	0	13	19
20	Transportation	0	14	20
21	Other	0	15	21
22	Administrative	(59,310)	17	22
23	Direct Fees	0	18	23
24	Professional Fees	(45,364)	19	24
25	Dues & Subscriptions	(3,841)	20	25
26	Office & Clerical	(33,988)	21	26
27	Employee Benefits	0	22	27
28	Inservice Training & Expense	0	23	28
29	Travel & Seminar	(756)	24	29
30	Other Staff Administration	(1,164)	25	30
31	Insurance	(14,367)	26	31
32	Other	0	27	32
33	Depreciation	(218,574)	30	33
34	Amortization	0	31	34
35	Interest	(168,258)	32	35
36	Real Estate Taxes	(51,953)	33	36
37	Rent - Facilities & Grounds	(918)	34	37
38	Rent - Equipment & Vehicles	(3,451)	35	38
39	Other	0	36	39
40	Medically Necessary Transportation	0	38	40
41	Ancillary Service Centers	0	39	41
42	Barber & Beauty Shop	0	40	42
43	Coffee & Gift Shops	0	41	43
44	Provider Participation Fee	0	42	44
45	Other	(393,921)	43	45
46				46
47				47
48				48
49	Total	(1,490,703)		49

Resthave Home of Whiteside County
Medicaid Cost Report
09/01/19 - 08/31/20

Page 5 - Non-Care Supplemental Allocation Schedule

Desciption	Cost Center	Salary	Total Allow. Exp.	Direct Costs: Nursing Home	Direct Costs: Other	Expenses For Alloc.	Alloc. Method	Statistics: Nursing Home	Statistics: Other	Expenses: Nursing Home	Expenses: Other
Dietary	1	308,545	337,352			337,352	Meals Served	68,412	38,973	214,918	122,434
Food	2	-	242,728			242,728	Meals Served	68,412	38,973	154,635	88,093
Housekeeping	3	247,948	288,704			288,704	SQFT (1)	20,301	4,374	237,529	51,175
Laundry	4	-	10,346			10,346	SQFT (1)	20,301	4,374	8,512	1,834
Heat and Other Utilities	5	-	164,091			164,091	SQFT	20,301	19,792	83,088	81,003
Maintenance	6	86,907	208,188			208,188	SQFT	20,301	19,792	105,416	102,772
Other	7	-	-			-	Pat. Days	-	-	-	-
Medical Director	9	-	18,000	18,000		-	Dir. Staffing	-	-	18,000	-
Nursing and Medical Records	10	1,415,828	1,510,970	1,415,828		95,142	Dir. Staffing	1,415,828	246,959	1,496,839	14,131
Therapy	10a	-	-			-	Dir. Staffing	-	-	-	-
Activities	11	114,070	122,768			122,768	Pat. Days (1)	22,804	3,712	105,583	17,185
Social Services	12	86,133	86,357	86,357		(0)	Dir. Staffing	-	-	86,357	(0)
CNA Training	13	-	-			-	Dir. Staffing	-	-	-	-
Transportation	14	-	-			-	Pat. Days	-	-	-	-
Other	15	-	-			-	Pat. Days	-	-	-	-
Administrative	17	76,546	316,546	76,546		240,000	Net. Pat. Rev.	4,967,423	1,630,507	257,236	59,310
Directors Fees	18	-	-			-	N/A	-	-	-	-
Professional Fees	19	-	183,567			183,567	Net. Pat. Rev.	4,967,423	1,630,507	138,203	45,364
Dues and Subscriptions	20	-	15,542			15,542	Net. Pat. Rev.	4,967,423	1,630,507	11,701	3,841
Office and Clerical	21	108,071	137,534			137,534	Net. Pat. Rev.	4,967,423	1,630,507	103,546	33,988
Employee Benefits	22	-	401,600			401,600	Salaries	2,202,765	575,789	318,378	83,222
Inservice Training and Expense	23	-	-			-	Pat. Days	-	-	-	-
Travel and Seminar	24	-	3,061			3,061	Net. Pat. Rev.	4,967,423	1,630,507	2,304	756
Other Staff Transportation	25	-	4,710			4,710	Net. Pat. Rev.	4,967,423	1,630,507	3,546	1,164
Insurance	26	-	58,136			58,136	Net. Pat. Rev.	4,967,423	1,630,507	43,770	14,367
Other	27	-	-			-	N/A	-	-	-	-
Depreciation	30	-	442,772			442,772	SQFT	20,301	19,792	224,198	218,574
Amortization	31	-	-			-	Net. Pat. Rev.	-	-	-	-
Interest	32	-	340,846			340,846	SQFT	20,301	19,792	172,588	168,258
Real Estate Taxes	33	-	105,243			105,243	SQFT	20,301	19,792	53,290	51,953
Rent - Facilities and Grounds	34	-	1,860			1,860	SQFT	20,301	19,792	942	918
Rent - Equipment and Vehicles	35	-	13,964			13,964	Net. Pat. Rev.	4,967,423	1,630,507	10,513	3,451
Other	36	-	-			-	N/A	-	-	-	-
Medically Necessary Transportation	38	-	-			-	N/A	-	-	-	-
Ancillary Service Centers	39	-	386,118	386,118	-	-	Direct	-	-	386,118	-
Barber and Beauty Shop	40	-	13,165	13,165		-	Direct	-	-	13,165	-
Coffee and Gift Shops	41	-	-			-	Direct	-	-	-	-
Provider Participation Fee	42	-	166,476	166,476	-	-	Direct	-	-	166,476	-
Other	43	334,282	393,921		393,921	-	Direct	-	-	-	393,921
		2,778,330	5,974,563	2,162,489	393,921	3,418,152				4,416,850	1,557,713

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	(122,434)	0	0	0	0	0	0	0	0	0	0	(122,434)	1
2	Food Purchase	(90,137)	0	0	0	0	0	0	0	0	0	0	(90,137)	2
3	Housekeeping	(51,175)	0	0	0	0	0	0	0	0	0	0	(51,175)	3
4	Laundry	(1,834)	0	0	0	0	0	0	0	0	0	0	(1,834)	4
5	Heat and Other Utilities	(117,074)	0	0	0	0	0	0	0	0	0	0	(117,074)	5
6	Maintenance	(102,987)	0	0	0	0	0	0	0	0	0	0	(102,987)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(485,640)	0	0	0	0	0	0	0	0	0	0	(485,640)	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	(14,131)	0	0	0	0	0	0	0	0	0	0	(14,131)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(17,185)	0	0	0	0	0	0	0	0	0	0	(17,185)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(31,315)	0	0	0	0	0	0	0	0	0	0	(31,315)	16
	C. General Administration													
17	Administrative	(59,310)	0	0	0	0	0	0	0	0	0	0	(59,310)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,019)	0	0	0	0	0	0	0	0	0	0	(60,019)	19
20	Fees, Subscriptions & Promotions	(3,895)	0	0	0	0	0	0	0	0	0	0	(3,895)	20
21	Clerical & General Office Expenses	(103,079)	0	0	0	0	0	0	0	0	0	0	(103,079)	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	(756)	0	0	0	0	0	0	0	0	0	0	(756)	24
25	Other Admin. Staff Transportation	(1,164)	0	0	0	0	0	0	0	0	0	0	(1,164)	25
26	Insurance-Prop.Liab.Malpractice	(14,367)	0	0	0	0	0	0	0	0	0	0	(14,367)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(242,589)	0	0	0	0	0	0	0	0	0	0	(242,589)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(759,545)	0	0	0	0	0	0	0	0	0	0	(759,545)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(218,574)	0	0	0	0	0	0	0	0	0	0	(218,574)	30
31	Amortization of Pre-Op. & Org.	(1,224)	0	0	0	0	0	0	0	0	0	0	(1,224)	31
32	Interest	(170,098)	0	0	0	0	0	0	0	0	0	0	(170,098)	32
33	Real Estate Taxes	(51,953)	0	0	0	0	0	0	0	0	0	0	(51,953)	33
34	Rent-Facility & Grounds	(918)	0	0	0	0	0	0	0	0	0	0	(918)	34
35	Rent-Equipment & Vehicles	(3,451)	0	0	0	0	0	0	0	0	0	0	(3,451)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(446,218)	0	0	0	0	0	0	0	0	0	0	(446,218)	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):*	(393,921)	0	0	0	0	0	0	0	0	0	0	(393,921)	43
44	TOTAL Special Cost Centers	(393,921)	0	0	0	0	0	0	0	0	0	0	(393,921)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,599,685)	0	0	0	0	0	0	0	0	0	0	(1,599,685)	45

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	Board of Directors							1
2								2
3	Mary Beswick							3
4	Gretchen Bush							4
5	Michelle Workman							5
6	Duane Habben							6
7	John Hauptman							7
8	Jerry Lindsey							8
9	Louise Thomas Parrish							9
10	Susan Tegeler							10
11	Chick West							11
12	Marcia Haag							12
13	Martin Schuette							13
14	Stephany Trossbach							14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	USDA		X	Facility Expansion Project			$ 7,420,000	$ 7,816,370	05/18/55	3.50%	$ 248,663	1
2	Triumph Bank		X	Facility Expansion Project			4,680,000	4,578,986	09/21/55	5.23%	72,614	2
3												3
4												4
5												5
	Working Capital											
6	Triumph Bank		X	Working Capital				240,903	02/01/23	5.50%	18,143	6
7	City of Morrison		X	Working Capital			300,000	102,379	09/21/23	3.00%	3,266	7
8												8
9	TOTAL Facility Related						$ 12,400,000	$ 12,738,638			$ 342,686	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(1,840)	11
12	Non-Allowable: Asst Living										(168,258)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (170,098)	14
15	TOTALS (line 9+line14)						$ 12,400,000	$ 12,738,638			$ 172,588	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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	30,023	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.)	$	41,909	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,886	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	41,404	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.	$	53,290	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	138,936	8
2016	83,136	9
2017	83,489	10
2018	86,349	11
2019	82,767	12

FOR BHF USE ONLY

Line	Item		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2020 Tax Accrual = ($82,767 * 1.4819)/12 * 8 = $122,654 * 50.63% = $41,404

Nursing Home Allocation = 50.63%

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resthave Home Whiteside Co COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09 - 17 - 352 - 015	Facility	$ 35,572.58	$ 18,012.10
2.	09 - 17 - 352 - 016	Facility	$ 47,193.98	$ 23,896.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,766.56	$ 41,908.68

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			$ 10,977	1
2					2
3	TOTALS			$ 10,977	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	$		$	$	$	4
5				1969	326,818						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	Various			2014	7,436						32
33	Various			2015	13,700,848						33
34	Various			2016	18,047						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	Accoustics - Dining Room	2017	$ 8,802	$		$	$	$	37
38	Pump Motor	2017	10,344						38
39	Roofing - Ridgevent & Cap Replacement	2020	2,600						39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48	Allocation - Non Care Assets								48
49	Prior Capital Report Assets		(8,051,621)						49
50	2016 (Allocation Method Square Footage)		(8,909)						50
51	2017 (Allocation Method Square Footage)		(9,451)						51
52	2018 (Allocation Method Square Footage)								52
53	2019 (Allocation Method Square Footage)								53
54	2020 (Allocation Method Square Footage)		(1,283)						54
55									55
56	Historical Assets Disposed		(330,945)						56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Depreciation			224,198		224,198		1,910,277	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,468,589	$ 224,198		$ 224,198	$	$ 1,910,277	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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	$ 663,980	$	$	$		$	71
72	Current Year Purchases	15,585						72
73	Fully Depreciated Assets							73
74	Non-Care Alloc.	(335,469)						74
75	TOTALS	$ 344,096	$	$	$		$	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	Resident Transportation	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	Non-Care Alloc.			(28,883)						79
80	TOTALS			$ 29,626	$	$	$		$	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)	$ 6,853,288	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 224,198	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,198	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)	$ 1,910,277	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	Land	$ 500	$	$	86
87	Building & Improvements	8,071,264			87
88	Equipment	335,469			88
89	Transportation	28,883			89
90	Depreciation		218,574	1,862,380	90
91	TOTALS	$ 8,436,116	$ 218,574	$ 1,862,380	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 Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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	See Suppl.				942			6
7	TOTAL				$ 942 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 10,513 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 Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Storage Rental	1,860	1,860
		-
Non-Allowable: Asst Living	(918)	(918)
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	942	942
Equipment Rental		
Acquarium & Bird Aviary	3,779	3,779
Office Equipment & Copiers	10,185	10,185
		-
Non-Allowable: Asst Living	(3,451)	(3,451)
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	10,513	10,513

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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		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	39 - 03	hrs	$		$ 112,545	$		$ 112,545	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			38,464			38,464	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			128,537			128,537	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				77,789		77,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					13,036		13,036	12
13	Other (specify): See Supplemental	39 - 03				15,747			15,747	13
14	TOTAL			$		$ 295,293	$ 90,825		$ 386,118	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 Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Oxygen		12,384		12,384
Therapy Supplies		652		652
Radiology			6,695	6,695
Laboratory			8,452	8,452
Other Services			600	600
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	13,036	15,747	28,783

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/20 (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	$ 2,768,566	$	1
2	Cash-Patient Deposits	9,529		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 135,000)	288,823		3
4	Supply Inventory (priced at Cost - FIFO)	8,062		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,146		6
7	Other Prepaid Expenses	6,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	243,783		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,329,496	$	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	14,443,485		14
15	Leasehold Improvements, at Historical Cost	96,368		15
16	Equipment, at Historical Cost	1,385,407		16
17	Accumulated Depreciation (book methods)	(3,772,657)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,641		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental	42,919		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,212,641	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,542,137	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 149,694	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,529		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,824		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,770		32
33	Accrued Interest Payable	294,720		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	336,445		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,070,981	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	343,281		39
40	Mortgage Payable	12,395,356		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,738,638	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,809,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,732,519	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,542,137	$	48

SEE ACCOUNTANTS' PREPARATION REPORT *(See instructions.)

Resthave Home Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Maintenance Reserve	190,578		190,578
Real Estate Escrow	53,205		53,205
			-
			-
			-
Sub-Total	243,783	-	243,783
Line 23 - Long Term Assets			
Loan Fees (Net of Amortization)	42,919		42,919
			-
			-
			-
			-
Sub-Total	42,919	-	42,919
Line 36 - Other Current Liability			
HHS Cares Act Grant - Unrecognized	336,445		336,445
			-
			-
			-
			-
Sub-Total	336,445	-	336,445
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 721,704	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 721,704	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,010,814	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)**	$ 1,010,814	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,732,519	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,967,423	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,967,423	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,168	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,168	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	13,484	13
14	Non-Patient Meals	2,044	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	215	16
17	Sale of Drugs	2,571	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)**	$ 18,314	23
	D. Non-Operating Revenue		
24	Contributions	35,808	24
25	Interest and Other Investment Income***	1,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,648	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**	250,000	27
28	See Supplemental	1,722,018	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,972,018	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,110,571	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,289,738	31
32	Health Care	1,738,094	32
33	General Administration	1,204,496	33
	B. Capital Expense		
34	Ownership	907,750	34
	C. Ancillary Expense		
35	Special Cost Centers	793,204	35
36	Provider Participation Fee	166,476	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,099,757	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,010,814	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,010,814	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,575,737	44
45	Private Pay - Net Inpatient Revenue	2,268,556	45
46	Medicare - Net Inpatient Revenue	919,219	46
47	Other-(specify) Insurance - Net Inpatient Revenue	130,495	47
48	Other-(specify) Veterans - Net Inpatient Revenue	73,416	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,967,423	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 Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 19 Supplemental Schedule

Description	Amount	Total
Assisted Living - Net Inpatient Revenue	1,630,507	1,630,507
HHS COVID-19 Grant	91,511	91,511
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	1,722,018	1,722,018

Facility Name & ID Number Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,080	$ 79,890	$ 38.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,312	10,622	335,981	31.63	3
4	Licensed Practical Nurses	11,850	12,756	303,669	23.81	4
5	CNAs & Orderlies	43,402	45,199	603,963	13.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,926	2,080	41,250	19.83	9
10	Activity Assistants	6,672	6,762	72,820	10.77	10
11	Social Service Workers	3,889	4,176	86,133	20.63	11
12	Dietician					12
13	Food Service Supervisor	1,838	2,067	40,208	19.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,125	23,214	268,337	11.56	15
16	Dishwashers					16
17	Maintenance Workers	5,667	5,973	86,907	14.55	17
18	Housekeepers	19,725	20,910	247,948	11.86	18
19	Laundry					19
20	Administrator	2,024	2,080	76,546	36.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,548	5,961	108,071	18.13	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	1,623	1,824	32,110	17.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	20,346	21,840	394,497	18.06	33
34	TOTAL (lines 1 - 33)	158,859	167,544	$ 2,778,330 *	$ 16.58	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,216	01 - 03	35
36	Medical Director		18,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,610	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		870	11 - 03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,696		49

C. CONTRACT NURSES

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

Resthave Home Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 20 Supplemental Schedule

Nursing Home Employees

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate
MDS Coordinator	10	1,972	2,080	60,215	28.95
Marketing Director	43	1,625	2,064	47,176	22.86
Assisted Living	43	16,749	17,696	287,106	16.22
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
Total		20,346	21,840	394,497	18.06

Contracted Services

Description	CC Reference	Hours Paid	Contracted Cost
Total		-	-

Facility Name & ID Number: Resthave Home Whiteside Co # 0005785 Report Period Beginning: 09/01/19 Ending: 08/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill Smith	Administrator	0	$ 76,546
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,546

B. Administrative - Other

Description	Amount
JHG, LLC - Management Services	$ 240,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 240,000

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris, LLP	Legal	$ 8,199
ADR Systems	Legal	4,250
Vanek, Larson & Kolb, LLC	Collections	10,405
Sikich, LLP	Accounting	18,500
Jeremy Brune & Assoc., LLC	Accounting	68,885
Clifton Larson Allen, LLP	Accounting	1,680
Clifton Larson Allen, LLP	IT Consulting	12,179
American Healthtec, Inc.	Data Processing	11,105
Point Click Care Tech, Inc.	Data Processing	36,921
Novatime Technologies, Inc.	Data Processing	5,148
Ability Network, Inc.	Data Processing	12,885
PTC Select	Data Processing	8,065
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 198,222

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,829
Unemployment Compensation Insurance	7,904
FICA Taxes	206,982
Employee Health Insurance	101,277
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,798
401K Administration	5,705
Other Benefits	33,105
TOTAL (agree to Schedule V, line 22, col.8)	$ 401,600

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	308
Health Care Worker Background Check (Indicate # of checks performed ____)	1,550
Patient Background Checks	
Association Dues	6,701
Dues and Subscriptions	2,234
Licenses and Fees	2,759
Alloc. Assisted Living	(3,841)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,701

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,060
Alloc. Assisted Living	(756)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,304

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Resthave Home Whiteside Co
Medicaid Cost Report
09/01/19 - 08/31/20

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Duane Morris, LLP	Facility Related Matters	09/30/19		318	-	318
Duane Morris, LLP	Facility Related Matters	10/31/19		280	-	280
Duane Morris, LLP	Facility Related Matters	12/31/19		477	-	477
Duane Morris, LLP	Facility Related Matters	01/31/20		5,880	-	5,880
Duane Morris, LLP	Facility Related Matters	02/29/20		1,244	-	1,244
ADR Systems	Non-Allowable	Non-Allowable		4,250	4,250	-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				12,449	4,250	8,199

Facility Name & ID Number **Resthave Home Whiteside Co** **# 0005785** **Report Period Beginning: 09/01/19** **Ending: 08/31/20**

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 - $6,000**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,487** 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. $ **166,476**
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? **See Pg. 2 Q. E** 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. $ **2,044**

(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? **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? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sikich (Not Final)**

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

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