

Facility Name & ID Number Red Bud Regional Care

0045476 Report Period Beginning: 7/1/16 Ending: 6/30/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	41,975	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	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,414	14,267	2,190	30,871	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,414	14,267	2,190	30,871	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.55%

D. How many bed reserve days during this year were paid by the Department?
 _____ (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)

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

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

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

I. On what date did you start providing long term care at this location?
 Date started 9/1/01

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 9/1/01 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 115 and days of care provided 2,032

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 6/30/17

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			491,792	491,792		491,792	774,397	1,266,189		1
2	Food Purchase										2
3	Housekeeping	117,543	30,160	312	148,015		148,015		148,015		3
4	Laundry	47,016	6,024	101,013	154,053		154,053		154,053		4
5	Heat and Other Utilities			93,339	93,339		93,339		93,339		5
6	Maintenance	8,283		6,361	14,644		14,644	36,288	50,932		6
7	Other (specify):*										7
8	TOTAL General Services	172,842	36,184	692,817	901,843		901,843	810,685	1,712,528		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,307,755	155,730	221,536	2,685,021		2,685,021	37,859	2,722,880		10
10a	Therapy	204,869		51	204,920		204,920		204,920		10a
11	Activities										11
12	Social Services	51,333		2,516	53,849		53,849		53,849		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,563,957	155,730	224,103	2,943,790		2,943,790	37,859	2,981,649		16
	C. General Administration										
17	Administrative	122,906		45,050	167,956	(16,537)	151,419	358,188	509,607		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			11,096	11,096		11,096		11,096		20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			742,458	742,458		742,458	40,432	782,890		22
23	Inservice Training & Education							7,328	7,328		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,254	67,254		67,254		67,254		26
27	Other (specify):*										27
28	TOTAL General Administration	122,906		865,858	988,764	(16,537)	972,227	405,948	1,378,175		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,859,705	191,914	1,782,778	4,834,397	(16,537)	4,817,860	1,254,492	6,072,352		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

Red Bud Regional Care

#0045476

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7/1/16

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			157,240	157,240		157,240	10,833	168,073			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,470	10,470		10,470		10,470			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,518	15,518		15,518	(10,264)	5,254			35
36	Other (specify):*											36
37	TOTAL Ownership			183,228	183,228		183,228	569	183,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					16,537	16,537		16,537			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			239,831	239,831		239,831		239,831			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			239,831	239,831	16,537	256,368		256,368			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,859,705	191,914	2,205,837	5,257,456		5,257,456	1,255,061	6,512,517			45

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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(204)	1		4
5	Telephone, TV & Radio in Resident Rooms	(10,264)	35		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,468)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	972,088		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 972,088		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 961,620		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops	X		16,537	17
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)			\$ 16,537	47

BHF USE ONLY							
48		49		50		51	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Red Bud Regional Care

0045476

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(204)	774,601	0	0	0	0	0	0	0	0	0	774,397	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	36,288	0	0	0	0	0	0	0	0	0	36,288	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(204)	810,889	0	810,685	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	37,859	0	0	0	0	0	0	0	0	0	37,859	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	37,859	0	37,859	16								
	C. General Administration													
17	Administrative	0	282,608	0	0	0	0	0	0	0	0	0	282,608	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	40,432	0	0	0	0	0	0	0	0	0	40,432	22
23	Inservice Training & Education	0	7,328	0	0	0	0	0	0	0	0	0	7,328	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	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	330,368	0	330,368	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(204)	1,179,116	0	1,178,912	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

7/1/16

Ending:

6/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	10,833	0	0	0	0	0	0	0	0	0	10,833	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(10,264)	0	0	0	0	0	0	0	0	0	0	(10,264)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,264)	10,833	0	569	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,468)	1,189,949	0	1,179,481	45								

Facility Name & ID Number

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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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$ 491,792	Red Bud Hospital		\$ 1,266,393	\$ 774,601	1
2	V	10 Nursing and Medical Records		Red Bud Hospital		37,859	37,859	2
3	V	6 Maintenance		Red Bud Hospital		36,288	36,288	3
4	V	117 Administration		Red Bud Hospital		75,580	75,580	4
5	V	23 Education		Red Bud Hospital		7,328	7,328	5
6	V	22 Employee Benefits		Red Bud Hospital		40,432	40,432	6
7	V							7
8	V	30 Depreciation Expense		QHCCS,LLC		8,687	8,687	8
9	V	30 Depreciation Expense		QHCCS,LLC		2,146	2,146	9
10	V	17 Corpoate Overhead		QHCCS,LLC		282,608	282,608	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 491,792			\$ 1,757,321	\$ * 1,265,529	14

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

Facility Name & ID Number

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

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VII. RELATED PARTIES (continued)

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

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization QHCCS, LLC
 Street Address 1573 Mallory Lane, STE 100
 City / State / Zip Code Brentwood, TN 37027
 Phone Number (615 371 4703
 Fax Number (615 371 4630

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Home Office Building Depr	Square Feet	4,398,162	\$ 1,110,388	\$	34,409	\$ 8,687	1
2	30	Home Office Equipment Depr	Square Feet	4,398,162	274,276		34,409	2,146	2
3	17	Officer Supplies	Man Hours	16,384,688	1,897,793	1,897,793	148,078	17,151	3
4	17	Other Corp Salaries	Man Hours	16,384,688	21,308,624	21,308,624	148,078	192,578	4
5	17	Contract Labor	Contract Labor Exp	20,978,688	627,376		166,212	4,971	5
6	17	Corporate Benefits	Man Hours	16,384,688	3,598,857		148,078	32,525	6
7	17	Corporate Expenses	Accumulated Cost	1,250,858,389	8,557,635		5,171,960	35,383	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				\$ 37,374,949	\$ 23,206,417		\$ 293,441	25

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7/1/16

Ending:

6/30/17

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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									14										
15	TOTALS (line 9+line14)									15										

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

* 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.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Red Bud Regional Care COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0045476

CONTACT PERSON REGARDING THIS REPORT David Perry

TELEPHONE 615 371 4703 FAX #: 615 371 4680

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-095-003-00</u>	<u>Attached</u>	\$ <u>54,570.72</u>	\$ <u>18,726.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>54,570.72</u></u>	\$ <u><u>18,726.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Red Bud Regional Care

0045476 Report Period Beginning:

7/1/16 Ending:

6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,409 B. General Construction Type: Exterior Brick Frame Concrete and Steel Number of Stories One

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 3 is shaded and labeled 'TOTALS'.

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

7/1/16

Ending:

6/30/17

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Carpeting for Nursing Home	1996		2,887		5			2,887	9
10		Fire Doors	1996		1,935	23	20	23		1,935	10
11		Grab Bars	1996		90		20			90	11
12		Renovation of East Wing Nurses' Station	1996		20,850		15			20,850	12
13		Renovation of Patient Room 105	1996		4,500		15			4,500	13
14		Renovation of West Wing Nurses' Station	1996		20,850		15			20,850	14
15		Reseal Parking Lot	1996		1,472		2			1,472	15
16		Roof Replacement	1996		99,865		10			99,865	16
17		Sandblast Entrance Sign	1996		1,750		10			1,750	17
18		Signs and Installation	1996		579		5			579	18
19		Wiring of East and West Wing Nurses's Station	1996		25,040	522	20	522		25,040	19
20		Final Landscaping	1996		2,350		10			2,350	20
21		Additional Renovations	1997		1,399	11	20	11		1,399	21
22		Laundry Renovations	1997		42,244		20			42,244	22
23		Hand rail	1998		3,042		10			3,042	23
24		Renovation of Patient Rooms and Corridors	1998		464,732	23,237	20	23,237		441,498	24
25		Schaefer Water Softener	1998		8,079		10			8,079	25
26		Vinyl Overlay	1998		1,998		10			1,998	26
27		West Corridor Floor Replacement	1998		6,000		10			6,000	27
28		Boiler Feed Pump	1999		1,601		10			1,601	28
29		Carpeting and Paint	1999		1,130		5			1,130	29
30		Room Remodel	1999		750	38	20	38		696	30
31		Additional Hardware	2000		55		10			55	31
32		Signage - Paint & Reletter Nursing Home Sign	2002		1,244		10			1,244	32
33		Carrier - Chiller 100 Ton	2003		75,360		12			75,360	33
34		Code Alert Wanderer System	2003		7,970		8			7,970	34
35		Keypad for Nursing Home Door	2003		2,138		15			2,138	35
36		Wanderguard System	2004		40,438		10			40,438	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 Red Bud Regional Care# 0045476

Report Period Beginning:

7/1/16

Ending:

6/30/17**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler - Lockinavar	2005	\$ 12,936	\$ 719	18	\$ 719	\$	\$ 8,985	37
38	Carpeting for Nursing Home	2055	7,503		5			7,503	38
39	Fire Alarm - Code Renovation for for Nursing Home	2008	4,768	477	10	477		4,093	39
40	Fire Alarm - Electrical Work	2008	4,650	465	10	465		4,003	40
41	Canopy - Nursing Home Entrance	2008	5,998	400	15	400		3,633	41
42	Nursing Home Code Repairs - Construction Fees	2008	127,187	8,479	15	8,479		72,778	42
43	Nursing Home Code Repairs - Curtains	2008	19,199		5			19,199	43
44	Carpet - Front Office & Center Office Areas	2008	7,566		5			7,566	44
45	Landscaping	2009	3,345	335	10	335		2,595	45
46	Capitalized Interest for CIP	2009	2,846	114	25	114		968	46
47	Electrical Work Add-ons to Generators	2009	23,650	2,365	10	2,365		19,511	47
48	Flooring - Removing of Tiles in 20 Patients Rooms	2009	18,000		5			18,000	48
49	Flooring, Tile for 20 Patient Room	2009	33,400	3,340	10	3,340		27,416	49
50	Canopy for Resident Patio	2009	1,163	78	15	78		636	50
51	Valances for Windows in Resident Rooms	2009	3,208		5			3,208	51
52	Emergency Generator	2010	22,556	1,128	20	1,128		7,989	52
53	Emergency Generator - Electrical Work	2010	12,250	613	20	613		4,341	53
54	Capitalized Interest for CIP	2011	6,604	264	25	264		1,848	54
55	Electrical Work Receptacles for Floor Removal	2011	3,225	215	15	215		1,451	55
56	Electical Work - NH Renovations	2011	64,037	4,269	15	4,269		28,816	56
57	Flooring - NH Renovations	2011	178,640	17,864	10	17,864		120,582	57
58	Asbestos Monitoring - west wing, east wing, hallway	2011	11,352	757	15	757		5,109	58
59	Flooring - Plank 2 med room, 2 untility room, 2 clean linen room	2011	2,430	243	10	243		1,640	59
60	Flooring - Rubber Floor and Plank 4 shower rooms, soiled rooms	2011	14,740	1,474	10	1,474		9,949	60
61	Flooring Plank and Non-slip VCT physical therapy, dining room, :	2011	13,654	1,365	10	1,365		9,214	61
62	Asbestos Removal - Patient rooms hallways and common areas	2011	80,000	5,333	10	5,333		35,998	62
63	Sprinkler System Upgrade - NH	2011	19,454	1,297	15	1,297		9,079	63
64	Sign - Care canter entrance	2012	5,057	140	15	140		714	64
65	Capitalized Interest for CIP	2012	2,178	43	25	43		258	65
66	Stuco and painting nursing home building	2011	27,500	4,583	5	4,583		27,500	66
67	cabinets - kitchenette	2011	963	32	15	32		192	67
68	cabinets - kitchenette	2011	964	32	15	32		192	68
69	countertops - kitchenette	2011	767	25	15	25		150	69
70	TOTAL (lines 4 thru 69)		\$ 1,582,138	\$ 80,280		\$ 80,280	\$	\$ 1,282,176	70

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

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	\$ 975,830	\$ 68,905	\$ 68,905	\$		\$ 710,546	71
72	Current Year Purchases	155,558	8,055	8,055			8,055	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,131,388	\$ 76,960	\$ 76,960	\$		\$ 718,601	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,713,526	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 157,240	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)	\$ 2,000,777	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/1	1880.25 hrs	\$ 69,173		\$	\$	1,880	\$ 69,173	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/1	761 hrs	35,081				761	35,081	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 104,254		\$	\$	2,641	\$ 104,254	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (41,540)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	634,933		3
4	Supply Inventory (priced at)	10,782		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,006		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 619,181	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	12,747		13
14	Buildings, at Historical Cost	347,891		14
15	Leasehold Improvements, at Historical Cost	1,048,357		15
16	Equipment, at Historical Cost	985,072		16
17	Accumulated Depreciation (book methods)	(1,332,317)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	12,709		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,074,459	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,693,640	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 68,584	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,700		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,200		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		527,081		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 779,565	\$	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)	\$ 779,565	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 914,075	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,693,640	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,383,956	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,383,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(469,881)	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)	\$ (469,881)	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)	\$ 914,075	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning: 7/1/16

Ending:

6/30/17

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,602,279	1
2	Discounts and Allowances for all Levels	(832,979)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,769,300	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	18,073	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	204	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,277	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,787,577	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	5,257,458	31
32	Health Care		32
33	General Administration		33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,257,458	40
41	Income before Income Taxes (line 30 minus line 40)**	(469,881)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (469,881)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,251,127	44
45	Private Pay - Net Inpatient Revenue	1,644,443	45
46	Medicare - Net Inpatient Revenue	640,776	46
47	Other-(specify)	232,954	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,769,300	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Red Bud Regional Care

0045476

Report Period Beginning:

7/1/16

Ending:

6/30/17

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	1,552	1,771	\$ 68,026	\$ 38.41	1
2	Assistant Director of Nursing	2,099	2,417	82,819	34.27	2
3	Registered Nurses	13,242	14,125	458,421	32.45	3
4	Licensed Practical Nurses	26,090	27,728	654,615	23.61	4
5	CNAs & Orderlies	62,535	66,825	892,556	13.36	5
6	CNA Trainees					6
7	Licensed Therapist	3,073	3,269	204,880	62.67	7
8	Rehab/Therapy Aides	2,685	2,919	68,087	23.33	8
9	Activity Director	1,763	2,092	31,987	15.29	9
10	Activity Assistants	1,840	2,076	24,294	11.70	10
11	Social Service Workers	3,191	3,947	51,334	13.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	463	463	8,283	17.89	17
18	Housekeepers	9,738	11,461	117,607	10.26	18
19	Laundry	3,638	4,064	47,016	11.57	19
20	Administrator	1,407	1,607	82,105	51.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,726	2,085	33,701	16.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	29	29	7,200	248.28	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,681	2,132	26,774	12.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,752	149,010	\$ 2,859,705 *	\$ 19.19	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	2,800	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	37	2,190	10/3	44
45	Social Service Consultant	37	2,190	10/3	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	74	\$ 7,180	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	3,595	107,945	10/3	52
53	TOTAL (lines 50 - 52)	3,595	\$ 107,945	53	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Amy Merritt	Admin	0	\$ 82,105	Workers' Compensation Insurance	\$ 159,540	IDPH License Fee	\$ 2,077	
Robin Vellett	Reception	0	33,601	Unemployment Compensation Insurance	28,104	Advertising: Employee Recruitment		
Amy Rohlifing	Med Dir	0	7,200	FICA Taxes	207,041	Health Care Worker Background Check		
		0	0	Employee Health Insurance	330,130	(Indicate # of checks performed <u>74</u>)	3,268	
				Employee Meals		Patient Background Checks	116 1,856	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois health Care Association	3,798	
				retirement Plan	14,596	Misc	97	
				Life Insurance	1,768			
				Other	1,279			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,906	TOTAL (agree to Schedule V, line 22, col.8)		\$ 11,096		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Beauty Shop Servies			\$ 16,537				Yellow page advertising ()	
Cost report prep fees			6,500				TOTAL (agree to Sch. V, line 20, col. 8)	
Postage supplies, Benefit Admin fees record Storage, Phone			22,013				\$ 11,096	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 45,050	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
			\$			\$	Out-of-State Travel	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Red Bud Regional Care# 0045476

Report Period Beginning:

7/1/16

Ending:

6/30/17**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. Ill Health Care Association \$3159
- (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? _____
- (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? _____
- (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? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,467 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 239,831
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? NA
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NA Has any meal income been offset against related costs? Yes Indicate the amount. \$ 204
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? No
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? NA
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. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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. NA
Attach invoices and a summary of services for all architect and appraisal fees