

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0045476 Facility Name: Red Bud Regional Care Address: 350 W South First St Red Bud 62278 Number City Zip Code County: Randolph Telephone Number: 618 282 3831 Fax # 618028204070 HFS ID Number: Date of Initial License for Current Owners: 9/1/01 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership X Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other
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In the event there are further questions about this report, please contact:

Name: Mark Shrout Telephone Number: (615) 221-3660

Email Address:

Facility Name & ID Number Red Bud Regional Care

0045476 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

III. STATISTICAL DATA

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

	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	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,859</u>	<u>15,993</u>	<u>1,625</u>	<u>32,477</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,859</u>	<u>15,993</u>	<u>1,625</u>	<u>32,477</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.16%

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

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

N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/1/2011

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 9/1/2001 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 1,625

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 6/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 07/01/2015 Ending: 06/30/2016
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary			476,772	476,772		476,772	806,222	1,282,994			1
2	Food Purchase											2
3	Housekeeping	105,211	28,598		133,809		133,809	11,731	145,540			3
4	Laundry	42,687	5,238	102,465	150,390		150,390		150,390			4
5	Heat and Other Utilities											5
6	Maintenance	6,961		123,195	130,156	(20,731)	109,425	39,912	149,337			6
7	Other (specify):*											7
8	TOTAL General Services	154,859	33,836	702,432	891,127	(20,731)	870,396	857,865	1,728,261			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,162,708	145,042	236,861	2,544,612	12,186	2,556,798	43,042	2,599,840			10
10a	Therapy	135,884		23,380	159,264		159,264		159,264			10a
11	Activities											11
12	Social Services	44,783		2,489	47,272		47,272		47,272			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,343,375	145,042	262,730	2,751,147	12,186	2,763,333	43,042	2,806,375			16
	C. General Administration											
17	Administrative	142,890	1,268	(36,276)	107,882	(48,860)	59,022	101,874	160,896			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			6,396	6,396		6,396		6,396			20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			774,959	774,959		774,959	38,994	813,953			22
23	Inservice Training & Education							23,469	23,469			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	142,890	1,268	745,079	889,238	(48,860)	840,378	164,337	1,004,715			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,641,124	180,146	1,710,242	4,531,512	(57,405)	4,474,107	1,065,244	5,539,351			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			164,776	164,776	40,217	204,993		204,993			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			18,726	18,726		18,726		18,726			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,916	2,916		2,916	(9,549)	(6,633)			35
36	Other (specify):*											36
37	TOTAL Ownership			186,418	186,418	40,217	226,635	(9,549)	217,086			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					17,188	17,188		17,188			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			240,922	240,922		240,922		240,922			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			240,922	240,922	17,188	258,110		258,110			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,641,124	180,146	2,137,581	4,958,852		4,958,852	1,055,695	6,014,547			45

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

VI. ADJUSTMENT DETAIL

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

	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	(282)	1		4
5	Telephone, TV & Radio in Resident Rooms	(9,549)	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)	\$ (9,831)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (9,831)		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

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 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(282)	806,504	0	0	0	0	0	0	0	0	0	806,222	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	11,731	0	0	0	0	0	0	0	0	0	11,731	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	39,912	0	0	0	0	0	0	0	0	0	39,912	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(282)	858,147	0	0	0	0	0	0	0	0	0	857,865	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	43,042	0	0	0	0	0	0	0	0	0	43,042	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	43,042	0	0	0	0	0	0	0	0	0	43,042	16
	C. General Administration													
17	Administrative	0	101,874	0	0	0	0	0	0	0	0	0	101,874	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	38,994	0	0	0	0	0	0	0	0	0	38,994	22
23	Inservice Training & Education	0	23,469	0	0	0	0	0	0	0	0	0	23,469	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	164,337	0	0	0	0	0	0	0	0	0	164,337	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(282)	1,065,526	0	0	0	0	0	0	0	0	0	1,065,244	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	(9,549)	0	0	0	0	0	0	0	0	0	0	(9,549)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,549)	0	0	0	0	0	0	0	0	0	0	(9,549)	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)	(9,831)	1,065,526	0	0	0	0	0	0	0	0	0	1,055,695	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Quorum Health</u>	<u>100%</u>			<u>Red Bud Hospital</u>	<u>Red Bud</u>	<u>Hospital</u>

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	<u>Housekeeping</u>	\$	<u>Red Bud Hospital</u>		\$ <u>11,731</u>	\$ <u>11,731</u>	1
2	V	6	<u>Maintenance</u>		<u>Red Bud Hospital</u>		<u>39,912</u>	<u>39,912</u>	2
3	V	7	<u>Security</u>		<u>Red Bud Hospital</u>				3
4	V	10	<u>Nursing and Medical Records</u>		<u>Red Bud Hospital</u>		<u>43,042</u>	<u>43,042</u>	4
5	V	17	<u>Administrative</u>		<u>Red Bud Hospital</u>		<u>101,874</u>	<u>101,874</u>	5
6	V	23	<u>Education</u>		<u>Red Bud Hospital</u>		<u>23,469</u>	<u>23,469</u>	6
7	V	22	<u>Employee Benefits</u>		<u>Red Bud Hospital</u>		<u>38,994</u>	<u>38,994</u>	7
8	V	1	<u>Dietary</u>	<u>476,772</u>	<u>Red Bud Hospital</u>		<u>1,283,276</u>	<u>806,504</u>	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ <u>476,772</u>			\$ <u>1,542,298</u>	\$ * <u>1,065,526</u>	14

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

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Red Bud Regional Hospital
Street Address 325 Spring Street
City / State / Zip Code Red Bud, IL 62278
Phone Number (731) 661-2000
Fax Number (731) 661-2187

	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	3	Housekeeping Management	% of time	100		\$ 31,074	\$ 45,000	30	\$ 9,322	1
2	17	Business Office Management	% of time	100		41,543	57,000	10	4,154	2
3	10	Health Information Systems	% of time	100		44,714	61,000	10	4,471	3
4	10	Nursing Administration - CNO	% of time	100		101,468	14,000	5	5,073	4
5	10	Quality Assurance - CQO	% of time	100		66,135	100,000	25	16,534	5
6	17	Administration - CEO	% of time	100		155,797	225,000	15	23,370	6
7	17	Administration - CFO	% of time	100		130,310	140,000	10	13,031	7
8	6	Maintenance	square footage	158,867		178,820	164,730	35,459	39,912	8
9	10	Material Management	% of supplies expense	240,000		85,041	79,464	29,256	10,366	9
10	23	Education	% of FTEs	250		61,735	57,380	74	18,274	10
11	17	Accounting	% of Operating Exp	4,500,000		128,616	119,452	742,050	21,209	11
12	7	Security	square footage	158,867		91,320	0	35,459	20,383	12
13	22	Employee Benefits	gross salaries B-1	8,925,341		1,867,589	159,133	159,133	33,298	13
14	1	Dietary	meals served B-1	159,761		1,887,960	0	121,961	1,441,262	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,872,122	\$ 1,222,159		\$ 1,660,659	25

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	18,726	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.)			\$	18,726	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		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.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	51,553	8	
		2012	53,813	9	
		2013	54,370	10	
		2014	54,625	11	
		2015	53,959	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Red Bud Regional Care COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0045476

CONTACT PERSON REGARDING THIS REPORT Mark Shrout

TELEPHONE (615) 221-3660 FAX #: (615) 221-1487

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 13-095-003-00	Attached	\$ 53,959.44	\$ 18,726.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 53,959.44	\$ 18,726.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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	97	20	97	0	1,912	10	
11	Grab Bars		1996		90	5	20	5		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' Station			1996		25,040	1,252	20	1,252	24,518	19	
20	Final Landscaping			1996		2,350		10		2,350	20	
21	Additional Renovations			1997		1,399	70	20	70	1,318	21	
22	Laundry Renovation			1997		42,244	2,112	20	2,112	41,187	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	418,261	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	658	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 Doors			2003		2,138		15		1,724	35	
36	Wanderguard System			2004		40,438		10		40,348	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:

07/01/2015 Ending: 06/30/2016

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

1		3	4			5	6	7	8	9	
Improvement Type**		Year Constructed	Cost			Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler - Lockinavar	2005	\$	12,936		\$ 719	18	\$ 719		\$ 8,266	37
38	Carpeting for Nursing Home	2005		7,503			5			7,503	38
39	Fire Alarm - Code Renovations for Nursing Home	2008		4,768		477	10	477		3,616	39
40	Fire Alarm - Electrical Work	2008		4,650		465	10	465		3,538	40
41	Canopy - Nursing Home Entrance	2008		5,998		400	15	400		3,233	41
42	Nursing Home Code Repairs - Construction Fees	2008		127,187		8,479	15	8,479		64,299	42
43	Nursing Home Code Repairs - Curtains	2008		19,199			5			19,199	43
44	Carpet - Fron Office & Center Office Areas	2008		7,566			5			7,566	44
45	Landscaping	2009		3,345		335	10	335		2,260	45
46	Capitalized Interest for CIP	2009		2,846		114	25	114		854	46
47	Electrical Work Add-ons to Generators	2009		23,650		2,365	10	2,365		17,146	47
48	Flooring - Removal of Tiles in 20 Patient Rooms	2009		18,000			5			18,000	48
49	Flooring, Tile for 20 Patient Rooms	2009		33,400		3,340	10	3,340		24,076	49
50	Canopy for Resident Patio	2009		1,163		78	15	78		558	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		6,861	52
53	Emergency Generator - Electrical Work	2010		12,250		613	20	613		3,728	53
54	Capitalized Interest for CIP	2011		6,604		264	25	264		1,584	54
55	Electrical Work - Receptacles for Floor Removal	2011		3,225		215	15	215		1,236	55
56	Electrical Work - NH Renovations	2011		64,037		4,269	15	4,269		24,547	56
57	Flooring - NH Renovations	2011		178,640		17,864	10	17,864		102,718	57
58	Asbestos Monitoring - west wing, east wing, hallway	2011		11,352		757	15	757		4,352	58
59	Flooring - Plank 2 med room, 2 utility room, 2 clean linen room	2011		2,430		243	10	243		1,397	59
60	Flooring - Rubber Floor and Plank 4 shower rooms, 4 soiled rooms	2011		14,740		1,474	10	1,474		8,475	60
61	Flooring - Plank and Non-slip VCT physical therapy, dining room, and D	2011		13,654		1,365	10	1,365		7,849	61
62	Asbestos Removal - patient rooms hallways and common areas	2011		80,000		5,333	10	5,333		30,665	62
63	Sprinkler System Upgrade - NH	2011		19,454		1,297	15	1,297		7,782	63
64	Sign - care center entrance	2012		5,057		140	15	140		574	64
65	Capitalized Interest for CIP	2012		2,178		43	25	43		215	65
66	Stucco and painting nursing home building	2011		27,500		4,583	5	4,583		22,915	66
67	cabinets - kitchenette	2011		963		32	15	32		160	67
68	cabinets - kitchenette	2011		964		32	15	32		160	68
69	countertops - kitchenette	2011		767		25	15	25		125	69
70	TOTAL (lines 4 thru 69)		\$	1,582,139		\$ 83,259		\$ 83,260	\$ 0	\$ 1,200,263	70

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

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
1	Totals from Page 12A, Carried Forward		\$ 1,582,139	\$ 83,259		\$ 83,260	\$ 0	\$ 1,200,263	1
2	electrical upgrade - NH	2011	21,050	526	20	526		2,104	2
3	flooring - chapel, administration, storage room	2011	12,618	630	10	630		2,520	3
4	front door, back door leading to hospital, door leading to patio	2011	25,943	1,946	10	1,946		7,784	4
5	dining room, chapel and bathroom renovation	2011	90,720	3,024	15	3,024		12,096	5
6	bathroom renovation	2011	21,500	716	15	716		2,864	6
7	flooring - small dining room	2011	5,950	298	10	298		1,192	7
8	sink - kitchenette	2011	349	11	15	11		44	8
9	electrical upgrade - nh	2011	10,000	250	20	250		1,000	9
10	flooring - therapy room	2011	1,350	67	10	67		268	10
11	Ac - rooftop	2011	13,150	1,096	10	1,096		4,384	11
12	Nurse on call system	2011	70,687	3,534	10	3,534		14,136	12
13	television - dining room	2011	1,475	245	5	245		980	13
14	ac - 2 patient rooms	2011	2,950	98	15	98		392	14
15	hvac - all patient rooms and entire building	2011	114,219	3,807	15	3,807		15,228	15
16	landscaping - nursing home	2012	4,345	435	10	435		1,739	16
17	nurse call system additional rooms (102 & 406)	2012	2,794	279	10	279		1,117	17
18	ac unit for laundry room	2013	8,250	550	15	550		2,200	18
19	wheelchair, rock & go	2013	1,564	104	15	104		417	19
20	television in chapel	2013	478	159	3	159		637	20
21	scale chair w/lift away arms & footrest 400lb max	2012	1,699	170	10	170		680	21
22	wheelchair, rock & go, color = port	2012	1,863	373	5	373		1,221	22
23	lift, sara 3000	2013	4,680	468	10	468		1,872	23
24	resident alarm system (6/30/14)	2014	23,500	2,350	10	2,350		4,700	24
25	wheelchair cushions	2014	3,090	172	3	172		516	25
26	chairs (vinyl)	2014	733	41	3	41		123	26
27	bed, bariatric with rails and foot control	2014	3,346	116	12	116		348	27
28	mattress, qty 42	2014	16,103	335	8	335		1,005	28
29	scale, wheelchair	2014	3,356	56	10	56		168	29
30	oxygen sensor, qty 4	2014	2,847	30	8	30		90	30
31	table, overbed, windsor mahogany, qty 44	2013	3,914	217	15	217		651	31
32	recline, blue ridge	2013	1,823	101	15	101		303	32
33	mattress, qty 14	2013	5,281	495	8	495		1,485	33
34	TOTAL (lines 1 thru 33)		\$ 2,063,766	\$ 105,958		\$ 105,958	\$ 0	\$ 1,284,526	34

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

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	
1	Totals from Page 12B, Carried Forward		\$ 2,063,766	\$ 105,958		\$ 105,958	\$ 0	\$ 1,284,526	1
2	recliner	2013	2,112	82	15	82		164	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	TOTAL (lines 1 thru 33)		\$ 2,065,878	\$ 106,040		\$ 106,040	\$ 0	\$ 1,284,690	34

**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	\$ 1,004,214	\$ 68,905	\$ 68,905	\$		\$ 706,945	71
72	Current Year Purchases	(28,384)					(65,304)	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 975,830	\$ 68,905	\$ 68,905	\$		\$ 641,641	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	3,041,708
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	174,945
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	174,945
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	0
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,926,331

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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?YESNO
- If NO, see instructions.

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

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

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

9. Option to Buy:YESNO

Terms:

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: \$19,516

Description: See attached 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.

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

☐ 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

☒

☐

☐

2

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)		248		248
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 248	\$	\$ 248
10	SUM OF line 9, col. 1 and 2 (e)	\$ 248			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(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.)

	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	10a/1	1577.25	hrs	\$	58,127		\$	1,577	\$	58,127	1		
2	Licensed Speech and Language Development Therapist			hrs								2		
3	Licensed Recreational Therapist			hrs								3		
4	Licensed Physical Therapist	10a/1	734.5	hrs		29,704			735		29,704	4		
5	Physician Care			visits								5		
6	Dental Care			visits								6		
7	Work Related Program			hrs								7		
8	Habilitation			hrs								8		
9	Pharmacy			# of prescrpts								9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10		
11	Academic Education			hrs								11		
12	Other (specify):											12		
13	Other (specify):											13		
14	TOTAL				\$	87,831		\$		\$	2,312	\$	87,831	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (20,959)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	770,466		3
4	Supply Inventory (priced at)	5,914		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,070		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 765,491	\$	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	996,400		15
16	Equipment, at Historical Cost	900,282		16
17	Accumulated Depreciation (book methods)	(1,129,407)		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):	1,663		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,129,576	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,895,067	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,987	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,495		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,332		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	Other accrued liabilities	219,940		36
37	Due from (to) related party	18,357		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 511,111	\$	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)	\$ 511,111	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,383,956	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,895,067	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,797,970	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,797,970	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(414,014)	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)	\$ (414,014)	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)	\$ 1,383,956	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,363,038	1
2	Discounts and Allowances for all Levels	(695,719)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,667,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,911	13
14	Non-Patient Meals	282	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)	\$ 19,193	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)	\$ 4,686,512	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care		32
33	General Administration	4,958,853	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)*	\$ 4,958,853	40
41	Income before Income Taxes (line 30 minus line 40)**	(272,341)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (272,341)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,134,758	44
45	Private Pay - Net Inpatient Revenue	(899)	45
46	Medicare - Net Inpatient Revenue	601,353	46
47	Other-(specify) Self Pay	1,931,853	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,667,065	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.

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	1,454	1,606	\$ 64,734	\$ 40.31	1
2	Assistant Director of Nursing	2,112	2,184	72,544	33.22	2
3	Registered Nurses	10,975	11,706	317,783	27.15	3
4	Licensed Practical Nurses	27,181	29,680	641,876	21.63	4
5	CNAs & Orderlies	66,593	70,419	983,887	13.97	5
6	CNA Trainees					6
7	Licensed Therapist	4,054	4,474	135,883	30.37	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,859	2,122	29,941	14.11	9
10	Activity Assistants	2,148	2,385	25,608	10.74	10
11	Social Service Workers	3,515	3,956	44,783	11.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	472	472	6,960	14.75	17
18	Housekeepers	8,455	9,857	105,211	10.67	18
19	Laundry	3,160	3,762	42,687	11.35	19
20	Administrator	1,660	1,840	58,381	31.73	20
21	Assistant Administrator					21
22	Other Administrative	843	843	36,194	42.93	22
23	Office Manager					23
24	Clerical	2,084	2,401	39,214	16.33	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	1,959	2,116	26,331	12.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,524	149,823	\$ 2,632,017 *	\$ 17.57	34

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	29	9,600	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,766	10/3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	352	22,896	10a/3	43
44	Activity Consultant	37	2,489	11/3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	418	\$ 37,751		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

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

** See instructions.

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
			\$	Workers' Compensation Insurance	\$	159,540	IDPH License Fee	\$
				Unemployment Compensation Insurance		25,874	Advertising: Employee Recruitment	
				FICA Taxes		190,850	Health Care Worker Background Check	
				Employee Health Insurance		380,280	(Indicate # of checks performed 49)	2,510
				Employee Meals			Patient Background Checks 95	1,520
				Illinois Municipal Retirement Fund (IMRF)*				
				Retirement Plan		15,328		
				Life Insurance		1,787		
				Other		1,019		
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()
(List each licensed administrator separately.)							Non-allowable advertising	()
							Yellow page advertising	()
B. Administrative - Other								
Description			Amount					
Barber/Beauty Shop			\$ 17,188					
Fingerprints			35					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	774,678	TOTAL (agree to Sch. V,	\$ 4,030
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)							line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

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. LSN \$1,990
- (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? 8 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,754 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 240,922
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? N/A
- (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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (282)
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? 1.6
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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees