

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0050468</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Regency Care of Morris</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1095 Twilight Drive</u> <u>Morris</u> <u>60450</u>																																																	
Number City Zip Code																																																	
County: <u>Grundy</u>																																																	
Telephone Number: <u>(828) 324-8898</u> Fax # <u>Faxes not accepted</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td colspan="2">(Print Name and Title) _____</td></tr><tr><td colspan="2">(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td colspan="2">(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067</td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>		(Telephone) <u>(847) 517-7070</u> Fax # (847)517-7067		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																															
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Date of Initial License for Current Owners: <u>08/01/09</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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In the event there are further questions about this report, please contact:																																																	
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Regency Care of Morris

0050468 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

N/A

	1	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>123</u>	Skilled (SNF)	<u>123</u>	<u>45,018</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>123</u>	TOTALS	<u>123</u>	<u>45,018</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>14,564</u>	<u>3,466</u>	<u>10,543</u>	<u>28,573</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>14,564</u>	<u>3,466</u>	<u>10,543</u>	<u>28,573</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.47%

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

none (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)

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

☐

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

08/01/09

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 08/01/09

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number of beds certified 123 and days of care provided 3,254

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	225,338	32,630	17,490	275,458		275,458		275,458		1
2	Food Purchase		234,032		234,032		234,032		234,032		2
3	Housekeeping	-	2,770	169,044	171,814		171,814		171,814		3
4	Laundry	-	4,614	113,079	117,693		117,693		117,693		4
5	Heat and Other Utilities			129,632	129,632		129,632	2,039	131,671		5
6	Maintenance	48,169	26,143	160,652	234,964		234,964	(7,016)	227,948		6
7	Other (specify):*	-	-	-							7
8	TOTAL General Services	273,507	300,189	589,897	1,163,593		1,163,593	(4,977)	1,158,616		8
	B. Health Care and Programs										
9	Medical Director	-	-	18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,115,504	213,905	1,200	2,330,609		2,330,609	(3,572)	2,327,037		10
10a	Therapy	-	-	-							10a
11	Activities	87,955	3,535	2,389	93,879		93,879	(125)	93,754		11
12	Social Services	89,727	-	2,939	92,666		92,666		92,666		12
13	CNA Training	-	-	-							13
14	Program Transportation	-	-	-							14
15	Other (specify):*	-	-	-							15
16	TOTAL Health Care and Programs	2,293,186	217,440	24,528	2,535,154		2,535,154	(3,697)	2,531,457		16
	C. General Administration										
17	Administrative	99,348	-	386,044	485,392		485,392	(386,044)	99,348		17
18	Directors Fees			-							18
19	Professional Services			116,901	116,901		116,901	9,806	126,707		19
20	Dues, Fees, Subscriptions & Promotions			35,059	35,059		35,059	(1,011)	34,048		20
21	Clerical & General Office Expenses	85,659	22,965	29,295	137,919		137,919	310,963	448,882		21
22	Employee Benefits & Payroll Taxes			872,296	872,296		872,296		872,296		22
23	Inservice Training & Education			-							23
24	Travel and Seminar			1,794	1,794		1,794	538	2,332		24
25	Other Admin. Staff Transportation		-	8,559	8,559		8,559	7,757	16,316		25
26	Insurance-Prop.Liab.Malpractice			218,783	218,783		218,783	429	219,212		26
27	Other (specify):* HO Alloc - Benefits			-				39,517	39,517		27
28	TOTAL General Administration	185,007	22,965	1,668,731	1,876,703		1,876,703	(18,045)	1,858,658		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,751,700	540,594	2,283,156	5,575,450		5,575,450	(26,719)	5,548,731		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			97,511	97,511		97,511	19,930	117,441			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			61,973	61,973		61,973	32,396	94,369			32
33	Real Estate Taxes			57,000	57,000		57,000	475	57,475			33
34	Rent-Facility & Grounds			727,572	727,572		727,572		727,572			34
35	Rent-Equipment & Vehicles			46,297	46,297		46,297	5,102	51,399			35
36	Other (specify):*			-								36
37	TOTAL Ownership			990,353	990,353		990,353	57,903	1,048,256			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	181,139	832,258	1,013,397		1,013,397	(251,780)	761,617			39
40	Barber and Beauty Shops	-	-	347	347		347		347			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			216,839	216,839		216,839		216,839			42
43	Other (specify):* Non-Allowable Cos	-	-	544,619	544,619		544,619	(544,619)				43
44	TOTAL Special Cost Centers		181,139	1,594,063	1,775,202		1,775,202	(796,399)	978,803			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,751,700	721,733	4,867,572	8,341,005		8,341,005	(765,215)	7,575,790			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				4
5	Telephone, TV & Radio in Resident Rooms	(11,445)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,813	30		9
10	Interest and Other Investment Income	(390)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,459)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(505,000)	43		24
25	Fund Raising, Advertising and Promotional	(14,799)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(28,990)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (544,270)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(220,945)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (220,945)	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (765,215)	37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology	\$ (5,347)	43	1
2	Laboratory	(5,627)	43	2
3	Non-Allowable Chamber of Commerce Dues	(420)	20	3
4	Real Estate Tax	475	33	4
5	Lobbying	(3,120)	20	5
6	Offset Other Income	(125)	11	6
7	Offset Other Income	156	26	7
8	Offset Other Income	(3,572)	10	8
9	Offset Other Income	(2,401)	43	9
10	Non-Allowable HO Costs	(523)	43	10
11	Capitalize Repair Expenses	(8,486)	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(28,990)		49

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
See Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 6-Supplemental		

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		N/A	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ * 0	14

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

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	5	Utilities	\$	WW Healthcare Consultants, LLC	100.00%	\$ 2,039	\$ 2,039	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	1,470	1,470	16
17	V	17	Management Fees	386,044	WW Healthcare Consultants, LLC	100.00%	0	(386,044)	17
18	V	19	Legal Fees		WW Healthcare Consultants, LLC	100.00%	8,050	8,050	18
19	V	19	Accounting Fees		WW Healthcare Consultants, LLC	100.00%	4,215	4,215	19
20	V	20	Dues, Fees, Subs. & Promotions		WW Healthcare Consultants, LLC	100.00%	1,119	1,119	20
21	V	21	Salaries / Wages		WW Healthcare Consultants, LLC	100.00%	255,802	255,802	21
22	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	21,643	21,643	22
23	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	34,928	34,928	23
24	V	24	Travel/Seminar		WW Healthcare Consultants, LLC	100.00%	538	538	24
25	V	25	Other Admin Staff Transportation		WW Healthcare Consultants, LLC	100.00%	4,677	4,677	25
26	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	273	273	26
27	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	39,517	39,517	27
28	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	1,117	1,117	28
29	V	32	Interest	61,152	WW Healthcare Consultants, LLC	100.00%	93,938	32,786	29
30	V	35	Rent		WW Healthcare Consultants, LLC	100.00%	5,102	5,102	30
31	V	43	Other Costs		WW Healthcare Consultants, LLC	100.00%	523	523	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 447,196			\$ 474,951	\$ * 27,755	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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)	
15	V	22	Employee Benefits - Work. Comp	\$ 85,788	SCK Assurance, LLC		\$ 85,788	\$	15
16	V	22	Employee Benefits - Health Insurance	54,915	SCK Assurance, LLC		54,915		16
17	V	26	Insurance - Gen & Prof Liability	169,416	SCK Assurance, LLC		169,416		17
18	V	26	Insurance - RAC Audit	14,165	SCK Assurance, LLC		14,165		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 324,284			\$ 324,284	\$ * 0	39

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

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	25	Other Admin Staff Transportation	\$ 3,080	DMG Aero		\$ 6,160	\$ 3,080	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 3,080			\$ 6,160	\$ * 3,080	39

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

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	39	Physical Therapy	\$ 391,138	AdaptNC, LLC		\$ 272,701	\$ (118,437)	15
16	V	39	Occupational Therapy	333,597	AdaptNC, LLC		232,584	(101,013)	16
17	V	39	Speech Therapy	106,769	AdaptNC, LLC		74,439	(32,330)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 831,504			\$ 579,724	\$ * (251,780)	39

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

VII. RELATED PARTIES (continued)

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

☒ 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)	
15	V	26	Insurance	\$ 12,177	T&C Reinsurance Protected Cell Company, LTD		\$ 12,177	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 12,177			\$ 12,177	\$ * 0	39

* 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	Morris Sterling Holdings, LLC	100	Regency Care of Black Mountain	North Carolina	Sterling Cottages LLC	Sterling, IL	Independent Liv.	1
2			Regency Care of Mount Sterling	Kentucky	Morris Cottages LLC	Morris, IL	Independent Liv.	2
3			Regency Care of Blountstown	Florida	N100LW, LLC	Hickory, NC	Airplane entity	3
4			Regency Care of Sterling	Sterling, IL	DMG Aero , LLC	Hickory, NC	Airplane entity	4
5			Regency Care of Arlington, LLC	Virginia	Regency Care Holding	Hickory, NC	Holding Co.	5
6			Regency Care of Silver Spring LLC	Silver Spring, MD	SCK Assurance LLC	Hickory, NC	Insurance Co.	6
7			Sapphire Health Care LLC	Copley, OH	WW Healthcare Cons	Hickory, NC	Mgmt Co.	7
8			(DBA Regency Care of Copley)		Regency Memory Car	Mount Sterling, KY	Assisted Living	8
9					AdaptNC, LLC	North Carolina	Therapy	9
10					T&C Reinsurance Pro	Norcross, GA	Insurance Co.	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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Note: No owners received compensation from this facility.								\$		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 Regency Care of Morris# 0050468

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WW Healthcare Consultants, LLC
 Street Address 1978 8th Avenue NW
 City / State / Zip Code Hickory, NC 28601
 Phone Number (828) 324-8898
 Fax Number (

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident days	266,620	9	\$ 19,023	\$ 28,573	\$ 2,039	1
2	6	Maintenance & Repair - Other	Resident days	266,620	9	13,717	28,573	1,470	2
3	19	Legal Fees	Resident days	266,620	9	75,111	28,573	8,050	3
4	19	Accounting Fees	Resident days	266,620	9	39,335	28,573	4,215	4
5	20	Dues, Fees, Subs. & Promotions	Resident days	266,620	9	10,441	28,573	1,119	5
6	21	Salaries / Wages	Resident days	266,620	9	2,386,940	2,386,940	255,802	6
7	21	Office/Other Supplies	Resident days	266,620	9	201,952	28,573	21,643	7
8	21	Clerical/General-Other	Resident days	266,620	9	325,921	28,573	34,928	8
9	24	Travel/Seminar	Resident days	266,620	9	5,021	28,573	538	9
10	25	Other Admin Staff Transportation	Resident days	266,620	9	43,639	28,573	4,677	10
11	26	Insurance	Resident days	266,620	9	2,552	28,573	273	11
12	27	Employee Benefits	Resident days	266,620	9	368,741	28,573	39,517	12
13	30	Depreciation	Resident days	266,620	9	10,427	28,573	1,117	13
14	32	Interest	Resident days	266,620	9	1,046	28,573	112	14
15	35	Rent	Resident days	266,620	9	47,609	28,573	5,102	15
16	43	Other Costs	Resident days	266,620	9	4,876	28,573	523	16
17									17
18	32	Interest	Direct Cost					93,826	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,556,352	\$ 2,386,940	\$ 474,951	25

Facility Name & ID Number Regency Care of Morris# 0050468 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization SCK Assurance LLC
Street Address 1978 8th Avenue NW
City / State / Zip Code Hickory, NC 28601
Phone Number (828 324-8898)
Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22	Employee Benefits-Work Comp	Direct Cost		\$	\$		\$ 85,788	1
2	22	Employee Benefits - Health Insur	Direct Cost					54,915	2
3	26	Insurance - Gen & Prof Liability	Direct Cost					169,416	3
4	26	Insurance - RAC Audit	Direct Cost					14,165	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 324,284	25

Ending: 12/31/20

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Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization AdaptNC, LLC
Street Address 1978 8th Avenue NW
City / State / Zip Code Hickory, NC 28601
Phone Number (828) 324-8898
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	39	Physical Therapy	Direct Cost			\$			\$ 272,701	1
2	39	Occupational Therapy	Direct Cost						232,584	2
3	39	Speech Therapy	Direct Cost						74,439	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 579,724	25

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	SBA-PPP Loan		X	Payroll & Oper Exp	None	5/4/2020	609,000	609,000	5/4/2022	0.0100	-		6
7													7
8													8
9	TOTAL Facility Related						\$ 609,000	\$ 609,000			\$		9
	B. Non-Facility Related*												
10								WW Healthcare Int Exp A			61,152		10
11								Finance Charges / Misc Int Exp			821		11
12								Interest Income Offset			(390)		12
13								Allocated from Home Office			32,786		13
14	TOTAL Non-Facility Related						\$	\$			\$ 94,369		14
15	TOTALS (line 9+line14)						\$ 609,000	\$ 609,000			\$ 94,369		15

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Morris SNF Management, LLC COUNTY Grundy

FACILITY IDPH LICENSE NUMBER 0050468

CONTACT PERSON REGARDING THIS REPORT Gene Woodward

TELEPHONE (828) 381-4923 FAX #: Please call, faxes may not be received.

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursin home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 02-33-303-020	Nursing Facility	\$ 57,474.78	\$ 57,474.78
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 57,474.78	\$ 57,474.78

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,744

B. General Construction Type: Exterior Brick Frame Wood 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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Regency Care of Morris# 0050468

Report Period Beginning:

01/01/20

Ending:

12/31/20**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Focus Fire		2009	6,096		5			6,096	9
10		Flooring		2009	3,774		5			3,774	10
11		Landscaping-Lava Rock		2009	6,723		10			6,723	11
12		Carpet		2009	3,183		5			3,183	12
13											13
14		New Wing Construction		2010	20,853	812	10	1,043	231	20,853	14
15		-Drywall work, doors, furniture, equipment, change heating									15
16		and air conditioning, 10 new exit signs									16
17											17
18		Emcor Repair									18
19		-Replace blower motor, 2 compressors, 2 belts, flushed out		2010	10,153	453	10	341	(112)	10,153	19
20		2 condensor coils, new motor, 2 new capacitors, new									20
21		thermostat, new temp sensor, replace supply line, clean									21
22		exchanger tubes air filter & trap, clean evaporator coil,									22
23		recharge 2 units									23
24		-New boiler flow switch, rewired controls, boiler relief valve,		2010	3,349	335	10	334	(0)	3,349	24
25		adjust boiler damper motor location, 2 new couplers									25
26											26
27		New sprinkler system : repipe N & S hallways, heads for N, S & W		2010	15,647	1,174	10	782	(392)	15,647	27
28		hallways, bathrooms & nursing station, pressure test									28
29											29
30		Hot Water Replacement		2010	4,800		10	240	240	4,800	30
31											31
32		HVAC and Sprinkler System throughout facility		2010	77,975		10	3,894	3,894	77,975	32
33		New Cooling Tower		2010	27,775		10	1,384	1,384	27,775	33
34		Renovate hallway and replace nursing station with private		2010	44,307		10	2,212	2,212	44,307	34
35		rooms - Gardens Hall									35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Regency Care of Morris

0050468

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Doors Done Right-6 Doors- Invoice 4563 4/8/2011	2011	\$ 7,004	\$	15	\$ 467	\$ 467	\$ 4,435	37
38	RF Technologies-Wanderer System	2011	9,531		5			9,531	38
39	Illinois Electric Services Inv 113009336,113011336,113014336 Elec	2011	9,350	935	10	935		8,883	39
40	Illinois Electric Services - Install code alert model	2011	7,300		7			7,300	40
41	Menards - BTU Window AC & Stand fan	2011	3,119		10	312	312	2,963	41
42	Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638		10	364	364	3,456	42
43									43
44	Sprinkler System - Nursing Home	2012	10,326	1,033	10	1,033	0	8,777	44
45	New Door Installation - Employee Entrance & Service Hall	2012	6,330	633	10	633	(0)	5,381	45
46	R/M Reclass: Chiller Condenser (outside, service entrance)	2012	2,762		5			2,762	46
47	Equipment Reclass: Generator (outside, off large dining rm.)	2012	4,617		5			4,617	47
48									48
49	Heat Pump Installation in Hallway One	2013	7,513	751	10	751		5,633	49
50	New Door Installation - Nursing Home	2013	13,137	1,314	10	1,314		9,855	50
51	New Fire Sprinkler Installation in Boiler Room	2013	5,750	575	10	575		4,313	51
52	R/M Reclass: Heat Pump & Blower-Hallway 1 (Dining RM & Kitch	2013	2,695		10	270	270	2,025	52
53	R/M Reclass: Garcia Masonry	2013	3,800		10	380	380	2,850	53
54									54
55	R/M Reclass: Guttering, corners, fascia & downspouts for bldg	2014	2,870		10	287	287	1,866	55
56	R/M Reclass: Building HVAC unit controls	2014	2,640		5			2,640	56
57	R/M Reclass: EMCOR-Replace Fan (HP#5); replace compressor	2014	5,230		5			5,230	57
58	for rooms 407/409; replace shower heat pump								58
59	R/M Reclass: Replace compressor for admin office & blower	2014	4,105		5			4,105	59
60	motor on the hall unit								60
61	R/M Reclass: Generator repair- Rear of building	2014	2,547		5			2,547	61
62	R/M Reclass: Repair of boiler & heat pump in kitchen, admin	2014	4,098		5			4,098	62
63	ofc, DON ofc. Cleaned & repaired when possible. Replaced								63
64	units where necessary.								64
65	Phones Plus Biz - Telephone system	2014	18,050		10	1,805	1,805	11,733	65
66	RF Technologies - Wanderer system	2014	17,335		5			17,335	66
67	D Construction inv 22294 - Driveway extension	2014	21,075	2,634	8	2,634	(0)	17,123	67
68	R/M Reclass: EMCOR-Replace compressor-Mech rm.-Inspect	2014	5,220		5			5,220	68
69	& evaluate 45 heat pumps-Replace/Repair where necessary								69
70	TOTAL (lines 4 thru 69)		\$ 404,678	\$ 10,649		\$ 21,990	\$ 11,341	\$ 379,313	70

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

Facility Name & ID Number Regency Care of Morris

0050468

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 404,678	\$ 10,649		\$ 21,990	\$ 11,341	\$ 379,313	1
2									2
3	Replacement of failed coil for the fluid cooler in the cooling tower	2015	53,850		10	5,385	5,385	29,618	3
4	R/M Reclass: EMCOR-Inspect & evaluate 11 heat pumps.	2015	3,633		5	363	363	3,633	4
5	Replace/Repair where necessary. Mechanical Room.								5
6									6
7	Walk-In Cooler. Kitchen	2016	7,366	491	15	491	(0)	2,210	7
8	Hot Water Heater. Mechanical Room	2016	8,086	809	10	809		3,638	8
9	5 Comfort Aire Heat Pumps	2016	24,785	2,479	10	2,479		11,153	9
10	Goldy Lock Door Replacement	2016	12,271	818	15	818	(0)	3,681	10
11	Air Cooled Chiller for HVAC. Mechanical Room	2016	51,800	3,453	15	3,453		15,540	11
12	Coil System. Mechical Room	2016	53,850	3,590	15	3,590		16,155	12
13	Flow Meters for Heat Pumps	2016	22,262	2,226	10	2,226	0	10,018	13
14	Turn Around in Front Building	2016	5,000	500	10	500		2,250	14
15	R&M Reclass: Replace pipe in fire system. Throughout Building	2016	17,924		25	717	717	3,226	15
16									16
17	2 Comfort Aire Heat Pumps	2017	10,119	1,012	10	2,481	1,469	7,949	17
18	Comfort Aire Heat Pump	2017	5,237	524	10	1,201	677	3,865	18
19									19
20	Chiller Compressor - Outside next to Patio	2018	5,353	357	15	357		828	20
21	New Signage - Outside & Throughout Building	2018	6,695	670	10	670		1,378	21
22	R&M Reclass: Replace pipe for laundry boilers and storage tank.	2018	7,116		25	285	285	712	22
23									23
24									24
25									25
26	Marseilles Inv 15-46006-Compressor	2019	5,687	1,137	5	1,137		2,066	26
27	Total Fire & Safety Inv 144296, 143570 Sprinkler Addition	2019	5,682	568	10	568		757	27
28	N&G Painting Inv 1092 - Dialysis Room Paint	2019	4,800	960	5	960		1,195	28
29	R&M Reclass: Dialysis Room Remodel & Paint	2019	3,600		5	720	720	1,080	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 719,794	\$ 30,242		\$ 51,200	\$ 20,957	\$ 500,265	34

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

Facility Name & ID Number Regency Care of Morris

0050468

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 719,794	\$ 30,242		\$ 51,200	\$ 20,957	\$ 500,265	1
2									2
3	Interior & Exterior Facility Renovations	2019	191,898	19,190	10	19,190	(0)	36,781	3
4	- Furnish And Install Water Heater in Mechanical Room								4
5	- Furnished and Installed Heat Pumps Throughout Facility								5
6	- Furnished And Installed New A/C, Replaced Thermostat, Checked								6
7	Evap Coil in Mechanical Room								7
8	- Furnished and Installed New Doors & Hinges, Wood Flooring								8
9	Throughout Facility								9
10	- Install Sprinkler Extension, Repair Piping & Damper, Grove								10
11	Coupling Throughout Facility								11
12	- Painting Halls, Common Areas & Resident Rooms Throughout								12
13	Facility								13
14	- Pulled Units/Replace Ceiling Heaters In Main Hall								14
15	- Re-Pipe Boiler, Replace Boiler, Pump, Relay Blower & Belt, Rewire								15
16	Control Board/Switches - 500 Hall								16
17	- Replace & Insulate Chiller & Water Pump in Villa								17
18	- Sealcoating & Striping Parking Lots, Lighting, Install Speed								18
19	Bumps & Storm Drain								19
20	- Test Blower Motor, Flushed Strainers, Replaced Coils, Rewiring								20
21	Voltage In Laundry Room								21
22									22
23	Replace Booster, Piping Throughout Building	2020	14,183	355	10	355		355	23
24	Replace Sprinkler Heads Throughout Building	2020	59,464	1,387	5	1,387		1,387	24
25	New PTAC Units for Entire Building	2020	369,741	6,162	5	6,162		6,162	25
26	New Paint and Flooring in Dialysis Room	2020	16,287	136	10	136		136	26
27	Drywall Repair in Corridor 1	2020	3,865	193	10	193		193	27
28	Replace Pipes in Attic	2020	4,621	231	10	231		231	28
29									29
30									30
31	Reconcile to Book Depreciation			99			(99)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,379,852	\$ 57,995		\$ 78,854	\$ 20,858	\$ 545,510	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	\$257,906	\$27,206	\$27,206	\$0	5-20 years	\$159,097	71
72	Current Year Purchases	57,575	2,114	2,114	0	10 years	2,114	72
73	Fully Depreciated Assets	128,811					128,811	73
74	Home Office Allocation			1,117	1,117			74
75	TOTALS	\$444,292	\$29,320	\$30,438	\$1,118		\$290,022	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	Facility Use	1998 Dodge Truck	2015	\$6,300	\$-	\$-		4	\$6,300	76
77	Facility Use	02 Dodge Van	2015	5,183	-	-		4	5,183	77
78	Facility Use	2009 E-350 Van	2017	14,985	3,746	3,746		4	13,111	78
79	Facility Use	2010 E-350 Van	2018	25,800	6,450	4,404	(2,046)	4	11,010	79
80	TOTALS			\$52,268	\$10,196	\$8,150	\$(2,046)		\$35,604	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)			\$1,876,41281
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$97,51182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$117,44183
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$19,93084
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$871,13685

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	N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress			
	Description	Cost	
92	CIP	\$1,305	92
93			93
94			94
95		\$1,305	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: WC-Morris LLC
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:		123	1/1/10	\$ 727,572			3
4	Additions							4
5								5
6								6
7	TOTAL		123		\$ 727,572			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 .
N/A
N/A
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: \$ 51,399 Description: See Sch 14A
(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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 3/26/2010

Ending 3/31/2025

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2021	\$ 732,811
13.	12/31/2022	\$ 753,915
14.	12/31/2023	\$ 775,628

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

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

Facility Name:

Regency Care of Morris

IDPH License ID Number:

0050468

Fiscal Year End:

12/31/20

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Equipment Rental-Nurse	41,741
Equipment Rental-Admin	499
Other Rent/Lease Expense	4,057
HO Allocation	5,102
Total - Line 16	51,399

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

It is the policy of this facility to only hire certified nurses aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)(7)	hrs	\$	3,797	\$ 232,277	\$	3,797	\$ 232,277	1
2	Licensed Speech and Language Development Therapist	39(3)(7)	hrs		1,046	74,621		1,046	74,621	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)(7)	hrs		4,616	272,827	3,536	4,616	276,363	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				162,097		162,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)(3)				753	15,506		16,259	12
13	Other (specify):									13
14	TOTAL			\$	9,459	\$ 580,478	\$ 181,139	9,459	\$ 761,617	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: Regency Care of Morris
IDPH License ID Number: 0050468
Fiscal Year End: 12/31/20

Schedule 16A

XIV. SPECIAL SERVICES (Direct Cost)
Line 12 Other (specify):

Outside Practitioner (other than consultant)			
Service	Units	Cost	Supplies
Supplies-RT			12,003
Other Inhalation/Respiratory			3,503
Contract Services-Other	N/A	753	
Total - Line 12 Other (specify):	-	753	15,506

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	\$ 45,676	\$ 45,676	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 670,054)	2,739,751	2,739,751	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	-	-	6
7	Other Prepaid Expenses	121,663	121,663	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Sch. 17A	1,250,367	1,250,367	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,157,457	\$ 4,157,457	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	-	13
14	Buildings, at Historical Cost	-	-	14
15	Leasehold Improvements, at Historical Cost	1,012,094	1,379,852	15
16	Equipment, at Historical Cost	513,528	496,560	16
17	Accumulated Depreciation (book methods)	(579,020)	(871,136)	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: CIP	1,305	1,305	22
23	Other(specify):	-	-	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 947,907	\$ 1,006,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,105,364	\$ 5,164,038	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,435,561	\$ 3,435,561	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	35,509	35,509	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	256,271	256,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	-	-	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,000	57,000	32
33	Accrued Interest Payable	-	-	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Sch. 17A	342,105	342,105	36
37		-	-	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,126,446	\$ 4,126,446	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	609,000	609,000	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)	\$ 609,000	\$ 609,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,735,446	\$ 4,735,446	46
47	TOTAL EQUITY (page 18, line 24)	\$ 369,918	\$ 428,592	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,105,364	\$ 5,164,038	48

*(See instructions.)

Facility Name:

Regency Care of Morris

IDPH License ID Number:

0050468

Fiscal Year End:

12/31/20

Schedule 17A

XV. Balance Sheet

Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Suspense	4,108	4,108
Real Estate Tax Escrow	523,359	523,359
Capital Improvements Escrow	(2,226)	(2,226)
Accrued Receivables	65,430	65,430
Resident Trust Cash	35,509	35,509
Deposits-Utilities	8,579	8,579
Deposits-Leases	72,344	72,344
Deposits-Other	1,374	1,374
W/H-Group Insurance	57,516	57,516
W/H-Employee Advances	2,842	2,842
Due To/From SCK	3,377	3,377
Due To/From UMR	22,315	22,315
Due to / from Symetra	1,240	1,240
Cont Liability-PPP Reserve Acc	411,075	411,075
Retro Revenue Reserve	43,525	43,525
Total - Line 9	1,250,367	1,250,367

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due To Medicaid (Credit Bal)	59,592	59,592
PTO Reserve Account	5,444	5,444
Health Savings Account	681	681
RC Benefits Liability Fund	50,424	50,424
Due To/From Employee-Health In	675	675
Contingent Liability-Stimulus	561,458	561,458
Cont Liability-Stimulus Reserv	(370,899)	(370,899)
Contingent Liability-Stimulus1	188,350	188,350
Contingent Liability-Stimulus1 Res	(188,350)	(188,350)
Contingent Liability-QIP	186,000	186,000
Cont Liability-QIP Res.	(186,000)	(186,000)
Cont Liability-State Stimulus	45,190	45,190
Cont Liability-State Stim Res	(45,190)	(45,190)
Contingent Liability-Phase 3 H	15,700	15,700
Contingent Liability-Phase 3 H Res	(15,700)	(15,700)
Escrows Payable to Wakefield	-	-
Reserve for Mcaid/Mcare Audit	34,730	34,730
Total - Line 36	342,105	342,105

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (611,176)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	383,999	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (227,177)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	597,095	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)	\$ 597,095	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)	\$ 369,918	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Regency Care of Morris

0050468

Report Period Beginning: 01/01/20

Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,784,072	1
2	Discounts and Allowances for all Levels	(3,427,333)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,356,739	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	4,824,725	6
7	Oxygen	-	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,824,725	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,217,214	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	-	13
14	Non-Patient Meals	-	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	328,429	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	2,279	19
20	Radiology and X-Ray	9,672	20
21	Other Medical Services	192,710	21
22	Laundry	-	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,750,304	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	390	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 390	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		-	28
28a	Other Revenue	5,942	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,942	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,938,100	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,163,593	31
32	Health Care	2,535,154	32
33	General Administration	1,876,703	33
	B. Capital Expense		
34	Ownership	990,353	34
	C. Ancillary Expense		
35	Special Cost Centers	1,558,363	35
36	Provider Participation Fee	216,839	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,341,005	40
41	Income before Income Taxes (line 30 minus line 40)**	597,095	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 597,095	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,575,534	44
45	Private Pay - Net Inpatient Revenue	1,812,952	45
46	Medicare - Net Inpatient Revenue	(1,917,158)	46
47	Other-(specify) <u>Managed Care</u>	(331,579)	47
48	Other-(specify) <u>Hospice</u>	216,990	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,356,739	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.

^Entity is a cash basis taxpayer.

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	1,929	1,929	\$ 80,812	\$ 41.88	1
2	Assistant Director of Nursing	1,001	1,063	30,412	28.61	2
3	Registered Nurses	13,918	14,480	479,715	33.13	3
4	Licensed Practical Nurses	15,065	15,965	480,160	30.08	4
5	CNAs & Orderlies	56,508	59,726	965,752	16.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,783	6,198	87,955	14.19	10
11	Social Service Workers	4,482	4,687	89,727	19.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,565	15,796	225,338	14.27	15
16	Dishwashers					16
17	Maintenance Workers	2,468	2,562	48,169	18.80	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,052	2,052	99,348	48.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,823	4,865	85,659	17.61	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					31
32	Other Health Care See Sch 20A	2,232	2,282	78,653	34.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,827	131,605	\$ 2,751,700 *	\$ 20.91	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	249	\$ 17,278	1(3)	35
36	Medical Director	36	18,000	9(3)	36
37	Medical Records Consultant	Monthly	1,200	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,389	11(3)	44
45	Social Service Consultant	48	2,939	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	381	\$ 41,806		49

C. CONTRACT NURSES

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

Facility Name: Regency Care of Morris
IDPH License ID Number: 0050468
Fiscal Year End: 12/31/20

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS Coordinator	1,459	1,459	63,149	\$ 43.27
Transportation - CNA	773	823	15,504	\$ 18.85
Total - Line 32 Other Health Care (specify):	2,232	2,282	78,653	

AIX. 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
Jennifer Tully	Administrator		\$ 99,335	Workers' Compensation Insurance	\$	99,362	IDPH License Fee	\$	1,990
Carolyn Progress	Administrator		13	Unemployment Compensation Insurance		64,550	Advertising: Employee Recruitment		4,147
				FICA Taxes		210,505	Health Care Worker Background Check		
				Employee Health Insurance		263,898	(Indicate # of checks performed 54)		535
				Employee Meals			Patient Background Checks 141		1,410
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees		6,306
							Miscellaneous Dues/Subscriptions		10,728
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits		233,981	Management company allocation		1,119
(List each licensed administrator separately.)			\$ 99,348				IHCA		11,353
B. Administrative - Other							Non-Allowable Dues		(3,540)
Description			Amount				Less: Public Relations Expense	(	
Management Fees - Eliminated in Column 7			\$ 386,044				Non-allowable advertising	(	
							Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 386,044	TOTAL (agree to Schedule V, line 22, col.8)			\$ 872,296	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description		Amount
Vendor/Payee	Type		Amount						
See Sch 21C	See Sch 21C		\$ 116,901	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		812
							Seminar Expense		982
							Allocated from Home Office		538
							Entertainment Expense	(	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 116,901					TOTAL	\$ 2,332

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Regency Care of Morris
IDPH License ID Number: 0050468
Fiscal Year End: 12/31/20

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	9,500
Income Tax Return	Accounting	3,000
Beth McCarty	HR Consultant	10,339
Iron Mountain	Data & Records Mgmt	2,192
SB2 Inc	Legal	25,200
O'Hagan Meyer, LLC	Legal	4,072
Polsinelli Shughart	Legal	3,142
Malmquist & Geiger	Legal Collections	1,000
Point Click Care	Data Processing	36,336
WW Health Care Consultants	Data Processing	3,340
Paylocity	Payroll Processing	17,746
Paycom	Payroll Processing	1,034
Total (agree to Schedule V, line 19, column 3)		116,901
Allocated from Management Company Legal Fees		8,050
Allocated from Management Company Professional Services		4,215
Less: Non-Allowable Legal Fees		(2,459)
Total (agree to Schedule V, line 19, column 8)		126,707

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$11,353
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,598 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. \$ 216,839
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ - Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.