FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 West South First Street (Number) Red Bud (City) 62278 (Zip Code)

County: Randolph

Telephone Number: (618) 282-3831 **Fax #** (618) 282-4070

HFS ID Number:

Date of Initial License for Current Owners: 9/1/01

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Julie Marshall **Telephone Number:** (615)465-7546
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/11 to 6/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Larry M. Carlton
(Title) Senior VP, Revenue Management

Paid Preparer

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

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	40,626	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	111	TOTALS	111	40,626	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,887	13,692	1,606	33,185	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,887	13,692	1,606	33,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.68%

D. How many bed-hold days during this year were paid by the Department?
465 (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 [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 111 and days of care provided 1,557

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary			438,490	438,490		438,490	1,177,194	1,615,684			1
2	Food Purchase											2
3	Housekeeping	109,117	24,466	88	133,671	(8)	133,663	12,260	145,923			3
4	Laundry	36,336	9,622	106,562	152,520		152,520		152,520			4
5	Heat and Other Utilities			92,850	92,850		92,850		92,850			5
6	Maintenance	7,909		22,983	30,892		30,892	46,981	77,873			6
7	Other (specify):*							18,547	18,547			7
8	**TOTAL General Services**	153,362	34,088	660,973	848,423	(8)	848,415	1,254,982	2,103,397			8
	B. Health Care and Programs											
9	Medical Director					10,000	10,000		10,000			9
10	Nursing and Medical Records	1,959,961	201,070	63,976	2,225,007		2,225,007	47,153	2,272,160			10
10a	Therapy	91,737		23,719	115,456		115,456		115,456			10a
11	Activities	54,412	1,047	9,817	65,276		65,276		65,276			11
12	Social Services	18,942		2,312	21,254		21,254		21,254			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,125,052	202,117	99,824	2,426,993	10,000	2,436,993	47,153	2,484,146			16
	C. General Administration											
17	Administrative	167,380	652	68,065	236,097	(26,871)	209,226	377,732	586,958			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			5,377	5,377	3,804	9,181	(151)	9,030			20
21	Clerical & General Office Expenses			2,160	2,160		2,160		2,160			21
22	Employee Benefits & Payroll Taxes			694,355	694,355	(3,804)	690,551	37,402	727,953			22
23	Inservice Training & Education							25,468	25,468			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			7,224	7,224		7,224		7,224			26
27	Other (specify):*											27
28	**TOTAL General Administration**	167,380	652	777,181	945,213	(26,871)	918,342	440,451	1,358,793			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,445,794	236,857	1,537,978	4,220,629	(16,879)	4,203,750	1,742,586	5,946,336			29

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

Facility Name & ID Number Red Bud Regional Care #0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			141,495	141,495		141,495	22,503	163,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(225)	(225)		(225)		(225)			32
33	Real Estate Taxes			12,130	12,130		12,130		12,130			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			46,838	46,838		46,838	(7,980)	38,858			35
36	Other (specify):*											36
37	TOTAL Ownership			200,238	200,238		200,238	14,523	214,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					16,879	16,879		16,879			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,136	63,136	16,879	80,015		80,015			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,445,794	236,857	1,801,352	4,484,003		4,484,003	1,757,109	6,241,112			45

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,265)	1		4
5	Telephone, TV & Radio in Resident Rooms	(7,980)	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	22,503	30		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	(382)	17		19
20	Contributions	(90)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	252,668	17		24
25	Fund Raising, Advertising and Promotional	(151)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 264,303		$	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)	1,492,806	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,492,806		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,757,109		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		16,879	17	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)**			$ 16,879		47

Red Bud Regional Care

ID# 0045476

Report Period Beginning: 7/1/11

Ending: 6/30/12

	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:** 7/1/11 **Ending:** 6/30/12

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,265)	1,179,459	0	0	0	0	0	0	0	0	0	1,177,194	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	12,260	0	0	0	0	0	0	0	0	0	12,260	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	46,981	0	0	0	0	0	0	0	0	0	46,981	6
7	Other (specify):*	0	18,547	0	0	0	0	0	0	0	0	0	18,547	7
8	**TOTAL General Services**	(2,265)	1,257,247	0	0	0	0	0	0	0	0	0	1,254,982	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	47,153	0	0	0	0	0	0	0	0	0	47,153	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	47,153	0	0	0	0	0	0	0	0	0	47,153	16
	C. General Administration													
17	Administrative	252,196	125,536	0	0	0	0	0	0	0	0	0	377,732	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	(151)	0	0	0	0	0	0	0	0	0	0	(151)	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	37,402	0	0	0	0	0	0	0	0	0	37,402	22
23	Inservice Training & Education	0	25,468	0	0	0	0	0	0	0	0	0	25,468	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**	252,045	188,406	0	0	0	0	0	0	0	0	0	440,451	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	249,780	1,492,806	0	0	0	0	0	0	0	0	0	1,742,586	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Red Bud Regional Care **#** 0045476 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	22,503	0	0	0	0	0	0	0	0	0	0	22,503	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	(7,980)	0	0	0	0	0	0	0	0	0	0	(7,980)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	14,523	0	0	0	0	0	0	0	0	0	0	14,523	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)	264,303	1,492,806	0	0	0	0	0	0	0	0	0	1,757,109	45

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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
Community Health Systems, Inc.	100			Red Bud Hospital	Red Bud	Hospital

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Red Bud Hospital		$ 12,260	$ 12,260	1
2	V	6	Maintenance		Red Bud Hospital		46,981	46,981	2
3	V	7	Security		Red Bud Hospital		18,547	18,547	3
4	V	10	Nursing and Medical Records		Red Bud Hospital		47,153	47,153	4
5	V	17	Administative		Red Bud Hospital		125,536	125,536	5
6	V	23	Education		Red Bud Hospital		25,468	25,468	6
7	V	22	Employee Benefits		Red Bud Hospital		37,402	37,402	7
8	V	1	Dietary	438,490	Red Bud Hospital		1,610,511	1,172,021	8
9	V	1	Cafeteria		Red Bud Hospital		7,438	7,438	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 438,490			$ 1,931,296	$ * 1,492,806	14

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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: 7/1/11 Ending: 6/30/12

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									$		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: 7/1/11 Ending: 6/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Red Bud Redional 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 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	3	Housekeeping Management	% of time	100		$ 40,866	$ 40,866	30	$ 12,260	1
2	17	Business Office Management	% of time	100		54,666	54,666	10	5,467	2
3	10	Health Information Systems	% of time	100		59,592	59,592	10	5,959	3
4	10	Nursing Administration - CNO	% of time	100		163,457	163,457	5	8,173	4
5	10	Quality Assurance - CQO	% of time	100		90,723	90,723	25	22,681	5
6	17	Administration - CEO	% of time	100		263,090	263,090	15	39,464	6
7	17	Administration - CFO	% of time	100		214,066	214,066	10	21,407	7
8	6	Maintenance	square footage	154,164		210,493	192,593	34,409	46,981	8
9	10	Material Management	% of supplies expense	237,172		84,827	76,631	28,911	10,340	9
10	17	Human Resources	% of FTEs	250		132,856	110,764	74	39,325	10
11	23	Education	% of FTEs	250		86,042	75,518	74	25,468	11
12	17	Accounting	% of Operating Exp	4,271,955		120,513	108,074	704,445	19,873	12
13	7	Security	square footage	154,164		83,095	0	34,409	18,547	13
14	22	Employee Benefits	gross salaries B-1	9,273,630		1,440,229	63,526	240,832	37,402	14
15	1	Dietary	meals served B-1	120,221		1,876,609	0	103,174	1,610,511	15
16	1	Cateteria	% of FTEs B-1	11,143		251,171	0	330	7,438	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,172,295	$ 1,513,566		$ 1,931,296	25

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	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.)**

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 15,450	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.)		$ 14,050	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,400)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,530	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.		$ 12,130	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008	51,977	9
2009	53,238	10
2010	52,696	11
2011	51,553	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 Julie Marshall

TELEPHONE 615-465-7546 FAX #: 615-373-2603

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-095-003-00	Attached	$ 51,553.16	$ 12,130.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,553.16	$ 12,130.00

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? x YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

X. BUILDING AND GENERAL INFORMATION:

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

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	Carpeting for Nursing Home			1996	2,887		5			2,887	9
10	Fire Doors			1996	1,932	97	20	97	(0)	1,513	10
11	Grab Bars			1996	90	5	20	5		73	11
12	Renovation of East Wing Nurses' Station			1996	20,850	463	15	463		20,850	12
13	Renovation of Patient Room 105			1996	4,500	125	15	125		4,500	13
14	Renovation of West Wing Nurses' Station			1996	20,850	579	15	579		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		19,510	19
20	Final Landscaping			1996	2,350		10			2,350	20
21	Additional Renovations			1997	1,399	70	20	70	(0)	1,038	21
22	Laundry Renovation			1997	42,244	2,112	20	2,112	0	32,739	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	(0)	325,313	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		506	30
31	Additional Hardware			2000	55		10			55	31
32	Signage - Paint & Reletter Nursing Home Sign			2002	1,244	93	10	93		1,244	32
33	Carrier - Chiller 100 Ton			2003	75,360	6,280	12	6,280	(0)	57,567	33
34	Code Alert Wanderer System			2003	7,970		8			7,970	34
35	Keypad for Nursing Home Doors			2003	2,138	143	15	143	0	1,295	35
36	Wanderguard System			2004	40,438	4,044	10	4,044	(0)	31,339	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler - Lockinavar	2005	$ 12,936	$ 719	18	$ 719	$ (0)	$ 5,390	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	(0)	1,708	39
40	Fire Alarm - Electrical Work	2008	4,650	465	10	465		1,666	40
41	Canopy - Nursing Home Entrance	2008	5,998	400	15	400	(0)	1,633	41
42	Nursing Home Code Repairs - Construction Fees	2008	127,187	8,479	15	8,479	0	30,383	42
43	Nursing Home Code Repairs - Curtains	2008	19,199	3,840	5	3,840	(0)	13,760	43
44	Carpet - Fron Office & Center Office Areas	2008	7,566	1,513	5	1,513	0	5,674	44
45	Landscaping	2009	3,345	335	10	335		920	45
46	Capitalized Interest for CIP	2009	2,846	114	25	114		398	46
47	Electrical Work Add-ons to Generators	2009	23,650	2,365	10	2,365		7,686	47
48	Flooring - Removal of Tiles in 20 Patient Rooms	2009	18,000	3,600	5	3,600		11,100	48
49	Flooring, Tile for 20 Patient Rooms	2009	33,400	3,340	10	3,340		10,716	49
50	Canopy for Resident Patio	2009	1,163	78	15	78	(0)	246	50
51	Valances for Windows in Resident Rooms	2009	3,208	642	5	642	(0)	1,711	51
52	Emergency Generator	2010	22,556	1,128	20	1,128	(0)	2,349	52
53	Emergency Generator - Electrical Work	2010	12,250	613	20	613		1,276	53
54	Capitalized Interest for CIP	2011	6,604	264	25	264	0		54
55	Electrical Work - Receptacles for Floor Removal	2011	3,225	215	15	215		376	55
56	Electrical Work - NH Renovations	2011	64,037	4,269	15	4,269	0	7,471	56
57	Flooring - NH Renovations	2011	178,640	17,864	10	17,864		31,262	57
58	Asbestos Monitoring - west wing, east wing, hallway	2011	11,352	757	15	757	(0)	1,324	58
59	Flooring - Plank 2 med room, 2 utility room, 2 clean linen room	2011	2,430	243	10	243		425	59
60	Flooring - Rubber Floor and Plank 4 shower rooms, 4 soiled rooms	2011	14,740	1,474	10	1,474		2,579	60
61	Flooring - Plank and Non-slip VCT physical therapy, dining room, and DC	2011	13,654	1,365	10	1,365	0	2,389	61
62	Asbestos Removal - patient rooms hallways and common areas	2011	80,000	5,333	15	5,333	0	9,333	62
63	Sprinkler System Upgrade - NH	2011	19,454	1,297	15	1,297	(0)		63
64	Sign - care center entrance	2012	5,057	140	15	140		140	64
65	Capitalized Interest for CIP	2012	2,178	43	25	43		43	65
66	Stucco and painting nursing home building	2011	27,500	4,583	5	4,583		4,583	66
67	cabinets - kitchenette	2011	963	32	15	32		32	67
68	cabinets - kitchenette	2011	964	32	15	32		32	68
69	countertops - kitchenette	2011	767	25	15	25		25	69
70	TOTAL (lines 4 thru 69)		$ 1,582,136	$ 104,579		$ 104,578	$ (2)	$ 821,248	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: 7/1/11 Ending: 6/30/12

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		$ 1,582,136	$ 104,579		$ 104,578	$ (2)	$ 821,248	1
2	electrical upgrade - NH	2011	21,050	526	20	526		526	2
3	flooring - chapel, administration, storage room	2011	12,618	630	10	630		630	3
4	front door, back door leading to hospital, door leading to patio	2011	25,943	1,946	10	1,946		1,946	4
5	dining room, chapel and bathroom renovation	2011	90,720	3,024	15	3,024		3,024	5
6	bathroom renovation	2011	21,500	716	15	716		716	6
7	flooring - small dining room	2011	5,950	298	10	298		298	7
8	sink - kitchenette	2011	349	11	15	11		11	8
9	electrical upgrade - nh	2011	10,000	250	20	250		250	9
10	flooring - therapy room	2011	1,350	67	10	67		67	10
11	Ac - rooftop	2011	13,150	1,096	10	1,096		1,096	11
12	Nurse on call system	2011	70,687	3,534	10	3,534		3,534	12
13	television - dining room	2011	1,475	245	5	245		245	13
14	ac - 2 patient rooms	2011	2,950	98	15	98		98	14
15	hvac - all patient rooms and entire building	2011	114,219	3,807	15	3,807		3,807	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)		$ 1,974,097	$ 120,827		$ 120,826	$ (2)	$ 837,496	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: 7/1/11 Ending: 6/30/12

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	$ 785,502	$ 61,686	$ 84,191	$ 22,505		$ 502,572	71
72	Current Year Purchases	264,705	13,103	13,103			13,103	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,050,207	$ 74,789	$ 97,294	$ 22,505		$ 515,675	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,024,304	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 195,616	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,120	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,503	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,353,171	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 46,839 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.

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	8

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	4

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		660		660
4	Clinical Wages (b)		330		330
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 991	$	$ 991
10	SUM OF line 9, col. 1 and 2 (e)	$ 991			

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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/1	782	hrs	$ 18,193		$	$	782	$ 18,193	1
2	Licensed Speech and Language Development Therapist	10a/3		hrs		95	6,966		95	6,966	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a/1	2057	hrs	73,544				2,057	73,544	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				$ 91,737	95	$ 6,966	$	2,934	$ 98,703	14

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (246,226)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	788,293		3
4	Supply Inventory (priced at)	7,902		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,052		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 559,021	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,646		13
14	Buildings, at Historical Cost	347,891		14
15	Leasehold Improvements, at Historical Cost	813,117		15
16	Equipment, at Historical Cost	873,825		16
17	Accumulated Depreciation (book methods)	(597,516)		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): Deferred MIS charge	1,627		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,448,590	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,007,611	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (66,049)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,082		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,290		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	Resident Trust Fund Liability	22,553		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 144,876	$	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	Intercompany Accounts	(3,419,453)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (3,419,453)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (3,274,577)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,282,188	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,007,611	$	48

***(See instructions.)**

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,974,088	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,974,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	308,100	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)**	$ 308,100	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)**	$ 5,282,188	24 *

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

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,570,149	1
2	Discounts and Allowances for all Levels	(802,039)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,768,110	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	2,500	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,142	13
14	Non-Patient Meals	2,265	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)**	$ 23,907	23
	D. Non-Operating Revenue		
24	Contributions	90	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 90	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)**	$ 4,792,107	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,484,004	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,484,004	40
41	**Income before Income Taxes (line 30 minus line 40)****	308,103	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 308,103	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	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.**

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,240	$ 76,392	$ 34.10	1
2	Assistant Director of Nursing	1,448	1,600	50,940	31.84	2
3	Registered Nurses	8,493	9,230	235,563	25.52	3
4	Licensed Practical Nurses	23,447	25,014	480,903	19.23	4
5	CNAs & Orderlies	87,317	93,088	1,068,477	11.48	5
6	CNA Trainees					6
7	Licensed Therapist	1,812	1,884	91,737	48.70	7
8	Rehab/Therapy Aides	1,022	1,022	23,693	23.19	8
9	Activity Director	2,020	2,319	28,824	12.43	9
10	Activity Assistants	1,877	2,222	25,588	11.52	10
11	Social Service Workers	1,931	2,094	18,942	9.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	297	426	7,909	18.57	17
18	Housekeepers	10,474	11,478	109,117	9.51	18
19	Laundry	3,815	3,987	36,336	9.11	19
20	Administrator	1,984	2,160	107,357	49.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,652	6,505	74,017	11.38	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,629	165,269	$ 2,435,795 *	$ 14.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	66	10,000	9/3	36
37	Medical Records Consultant				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	95	6,966	10a/3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	161	$ 16,966		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	43,275	583,644	10/3	52
53	TOTAL (lines 50 - 52)	43,275	$ 583,644		53

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
Bad Debt	$ 276,609
Barber Beauty	36,635
Background Checks	3,804
Other	88,299
TOTAL (agree to Schedule V, line 17, col. 3)	$ 405,347
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,746
Unemployment Compensation Insurance	33,509
FICA Taxes	173,770
Employee Health Insurance	349,095
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	40,384
Life Insurance	2,306
Other	545
TOTAL (agree to Schedule V, line 22, col.8)	$ 694,355

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	74
Health Care Worker Background Check	
(Indicate # of checks performed 108)	1,728
Patient Background Checks 54	3,804
Membership Dues	5,151
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,757

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,180
In-State Travel	1,175
Seminar Expense	6,046
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,401

**See instructions.

Facility Name & ID Number Red Bud Regional Care # 0045476 Report Period Beginning: 7/1/11 Ending: 6/30/12

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Red Bud Regional Care **#** 0045476 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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 $3,722**

(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? **9.33**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,954** 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. $ **63,136**
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 benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(2,265)**

(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? **95.22%**
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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.