FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0050468

Facility Name: Regency Care of Morris

Address: 1095 Twilight Drive (Number) Morris (City) 60450 (Zip Code)

County: Grundy

Telephone Number: (828) 324-8898 **Fax #** Faxes not accepted

HFS ID Number:

Date of Initial License for Current Owners: 08/01/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2015 to 12/31/2015 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	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	123	TOTALS	123	44,895	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	10,952	6,637	7,838	25,427	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,952	6,637	7,838	25,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.64%

D. How many bed-hold days during this year were paid by the Department?
none (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 [X] 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 [X]

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 [X] Date 08/01/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 35 and days of care provided 5,557

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	165,239	36,933	15,358	217,530		217,530		217,530			1
2	Food Purchase		173,222		173,222		173,222		173,222			2
3	Housekeeping	135,713	32,936		168,649		168,649		168,649			3
4	Laundry	39,765	9,044	1,721	50,531		50,531		50,531			4
5	Heat and Other Utilities			93,195	93,195		93,195	2,286	95,481			5
6	Maintenance	50,829	41,550	77,689	170,067		170,067	(2,095)	167,972			6
7	Other (specify):*											7
8	**TOTAL General Services**	391,546	293,685	187,963	873,194		873,194	191	873,385			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,670,367	125,912	28,965	1,825,244		1,825,244		1,825,244			10
10a	Therapy											10a
11	Activities	56,135	2,341	3,417	61,894		61,894		61,894			11
12	Social Services	68,585		1,127	69,712		69,712		69,712			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,795,088	128,254	51,508	1,974,850		1,974,850		1,974,850			16
	C. General Administration											
17	Administrative	88,854		321,354	410,208		410,208	(321,354)	88,854			17
18	Directors Fees											18
19	Professional Services			56,302	56,302		56,302	624	56,926			19
20	Dues, Fees, Subscriptions & Promotions			19,389	19,389		19,389	2,184	21,573			20
21	Clerical & General Office Expenses	91,634	34,668	54,270	180,571		180,571	180,313	360,884			21
22	Employee Benefits & Payroll Taxes			637,091	637,091		637,091		637,091			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,749	4,749		4,749	3,405	8,154			24
25	Other Admin. Staff Transportation			46,075	46,075		46,075		46,075			25
26	Insurance-Prop.Liab.Malpractice			143,627	143,627		143,627	1,134	144,761			26
27	Other (specify):* HO Alloc - Benefits							25,162	25,162			27
28	**TOTAL General Administration**	180,487	34,668	1,282,857	1,498,013		1,498,013	(108,532)	1,389,481			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,367,121	456,607	1,522,328	4,346,057		4,346,057	(108,341)	4,237,716			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 Regency Care of Morris #0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			45,575	45,575		45,575	38,636	84,211			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							28,369	28,369			32
33	Real Estate Taxes			81,359	81,359		81,359		81,359			33
34	Rent-Facility & Grounds			713,092	713,092		713,092		713,092			34
35	Rent-Equipment & Vehicles			40,031	40,031		40,031	4,220	44,251			35
36	Other (specify):*											36
37	TOTAL Ownership			880,056	880,056		880,056	71,225	951,281			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		356,256	578,051	934,308		934,308		934,308			39
40	Barber and Beauty Shops			21	21		21		21			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,484	184,484		184,484		184,484			42
43	Other (specify):* Non-Allowable Cos			124,538	124,538		124,538	(124,538)				43
44	TOTAL Special Cost Centers		356,256	887,094	1,243,350		1,243,350	(124,538)	1,118,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,367,121	812,863	3,289,478	6,469,463		6,469,463	(161,654)	6,307,809			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 Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(5,535)	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	34,236	30		9
10	Interest and Other Investment Income	(59)	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	(4,301)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,155)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,000)	43		24
25	Fund Raising, Advertising and Promotional	(17,250)	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 Page 5A	(37,762)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,826)		$	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)	(53,828)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (53,828)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (161,654)		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

Regency Care of Morris

ID# 0050468

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology	$ (9,636)	43	1
2	Laboratory	(14,816)	43	2
3	Capitalize Repairs Expenses	(3,633)	6	3
4	Disallow Rotary Club & Chamber of Commerce Dues	(785)	20	4
5	Other Revenue offset	(4,646)	21	5
6	Non allowable expense from Home Office	(2,087)	43	6
7	Lobbying	(490)	20	7
8	Disallow non-allowable meals & entertainment	(1,669)	24	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**	(37,762)		49

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
Morris Sterling Holdings, LLC	100	Regency Care of Mountain Ridge	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.
		Regency Care of Clemmons	North Carolina	Walnut Grove Cottage	Morris	Independent Liv.
		Regency Care of Mount Sterling	Kentucky	N100LW, LLC	Hickory, NC	Airplane entity
		Regency Care of Blountstown	Florida	DMG Aero , LLC	Hickory, NC	Airplane entity
		Regency Care of Sterling	Sterling, IL	Regency Care Holding	Hickory, NC	Holding Co.
		Regency Care of Arlington, LLC	Virginia	SCK Assurance, LLC	Hickory, NC	Insurance Co.
				WW Healthcare Const	Hickory, NC	Mgmt Co.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		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.**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] 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)	
15	V	5	Utilities	$	WW Healthcare Consultants, LLC		$ 2,286	$ 2,286	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC		1,538	1,538	16
17	V	17	Management Fees	321,354	WW Healthcare Consultants, LLC			(321,354)	17
18	V	19	Professional Services		WW Healthcare Consultants, LLC		4,779	4,779	18
19	V	20	Dues, Fees, Subs. & Promotions		WW Healthcare Consultants, LLC		749	749	19
20	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC		22,205	22,205	20
21	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC		10,988	10,988	21
22	V	21	Salaries/Wages		WW Healthcare Consultants, LLC		154,476	154,476	22
23	V	24	Travel/Seminar		WW Healthcare Consultants, LLC		5,074	5,074	23
24	V	26	Insurance		WW Healthcare Consultants, LLC		1,134	1,134	24
25	V	27	Employee Benefits		WW Healthcare Consultants, LLC		25,162	25,162	25
26	V	30	Depreciation		WW Healthcare Consultants, LLC		4,400	4,400	26
27	V	32	Interest		WW Healthcare Consultants, LLC		28,428	28,428	27
28	V	35	Rent		WW Healthcare Consultants, LLC		4,220	4,220	28
29	V	43	Other Costs		WW Healthcare Consultants, LLC		2,087	2,087	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			$ 321,354			$ 267,526	$ * (53,828)	39

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] 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)	
15	V	22	Employee Beneifts - Work. Comp	$ 79,972	SCK Assurance, LLC	0.00%	$ 79,972	$	15
16	V	26	Insurance - Gen & Prof Liability	59,232	SCK Assurance, LLC	0.00%	59,232		16
17	V	26	Insurance - RAC Audit	17,413	SCK Assurance, LLC	0.00%	17,413		17
18	V	26	Insurance - Health Insurance	30,110	SCK Assurance, LLC	0.00%	30,110		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			$ 186,728			$ 186,728	$ * 0	39

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			Note : No owners received compensation from this facility.								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: 01/01/2015 Ending: 2/31/2015

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: 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	242,035	7	$ 21,757	$	25,427	$ 2,286	1
2	6	Maintenance & Repair - Other	Resident days	242,035	7	14,640		25,427	1,538	2
3	19	Professional Services	Resident days	242,035	7	45,486		25,427	4,779	3
4	20	Dues, Fees, Subs. & Promotions	Resident days	242,035	7	7,134		25,427	749	4
5	21	Clerical/General-Other	Resident days	242,035	7	211,364		25,427	22,205	5
6	21	Office/Other Supplies	Resident days	242,035	7	104,588		25,427	10,988	6
7	21	Salaries/Wages	Resident days	242,035	7	1,470,426	1,470,426	25,427	154,476	7
8	24	Travel/Seminar	Resident days	242,035	7	48,303		25,427	5,074	8
9	26	Insurance	Resident days	242,035	7	10,798		25,427	1,134	9
10	27	Employee Benefits	Resident days	242,035	7	239,514		25,427	25,162	10
11	30	Depreciation	Resident days	242,035	7	41,884		25,427	4,400	11
12	32	Interest	Resident days	242,035	7	270,602		25,427	28,428	12
13	35	Rent	Resident days	242,035	7	40,168		25,427	4,220	13
14	43	Other Costs	Resident days	242,035	7	19,865		25,427	2,087	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,546,530	$ 1,470,426		$ 267,526	25

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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: SCK Assurance, 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	22	Employee Benefit-Work Comp	Direct Cost			$	$		$ 79,972	1
2	26	Insurance - Gen & Prof Liability	Direct Cost						59,232	2
3	26	Insurance - RAC Audit	Direct Cost						17,413	3
4	26	Insurance - Health Insurance	Direct Cost						30,110	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					$	$		$ 186,728	25

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	NRF Healthcare, LLC		X	Rent Arrearages	Demand	7/1/11	170,224		Demand			6
7												7
8												8
9	TOTAL Facility Related						$ 170,224	$			$	9
	B. Non-Facility Related*											
10								Offset interest income			(59)	10
11												11
12								HO Interest Allocation			28,428	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 28,369	14
15	TOTALS (line 9+line14)						$ 170,224	$			$ 28,369	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.)**

Facility Name & ID Number Regency Care of Morris # 0050468 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 86,000	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.)	2014	$ 83,359	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,641)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 84,000	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
	Allocated from Managment Co.		
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.		$ 81,359	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	121,856	8
	2011	90,178	9
	2012	85,918	10
	2013	85,457	11
	2014	83,359	12

Accrual Calculation: **PY Accrual: $86,000**
+ **CY RE Tax Expense: $83,359**
+ **Immaterial Variance: $641**
Total: **$84,000**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walnut Grove Village COUNTY Grundy

FACILITY IDPH LICENSE NUMBER 0050468

CONTACT PERSON REGARDING THIS REPORT Gene Woodard

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-33-301-013	Nursing Facility	$ 82,392.92	$ 82,392.92
2.	02-33-301-006	Nursing Facility	$ 559.12	$ 559.12
3.	02-33-353-025	Nursing Facility	$ 165.86	$ 165.86
4.	02-33-353-026	Nursing Facility	$ 241.00	$ 241.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,358.90	$ 83,358.90

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 a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

30 Cottages - Cost not included in cost report

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: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			N/A	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	672	10	672	(0)	4,368	11
12	Carpet			2009	3,183		5			3,183	12
13											13
14	New Wing Construction			2010	20,853	2,085	10	2,085	(0)	11,469	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	1,015	10	1,015	0	5,751	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	335	(0)	1,675	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	1,565	10	1,565	(0)	8,606	27
28	hallways, bathrooms & nursing station, pressure test										28
29											29
30	Hot Water Replacement			2010	4,800		10	480	480	2,640	30
31											31
32	HVAC and Sprinkler System throughout facility			2010	77,975		10	7,798	7,798	42,889	32
33	New Cooling Tower			2010	27,775		10	2,778	2,778	15,279	33
34	Renovate hallway and replace nursing station with private			2010	44,307		10	4,431	4,431	24,371	34
35	rooms - Gardens Hall										35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Doors Done Right-6 Doors- Invoice 4563 4/8/2011	2011	$ 7,004	$	15	$ 467	$ 467	$ 2,101	37
38	RF Technologies-Wanderer System	2011	9,531		5	1,906	1,906	8,578	38
39	Illinois Electric Services Inv 113009336,113011336,113014336 Elect	2011	9,350	935	10	935		4,208	39
40	Illinois Electric Services - Install code alert model	2011	7,300		7	1,043	1,043	4,692	40
41	Menards - BTU Window AC & Stand fan	2011	3,119		10	312	312	1,404	41
42	Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638		10	364	364	1,637	42
43									43
44	Sprinkler System - Nursing Home	2012	10,326	1,033	10	1,033	0	3,614	44
45	New Door Installation - Employee Entrance & Service Hall	2012	6,330	633	10	633	(0)	2,216	45
46	R/M Reclass: Chiller Condenser (outside, service entrance)	2012	2,762		5	552	552	1,933	46
47	Equipment Reclass: Generator (outside, off large dining rm.)	2012	4,617		5	923	923	3,232	47
48									48
49	Heat Pump Installation in Hallway One	2013	7,513	412	10	751	339	1,878	49
50	New Door Installation - Nursing Home	2013	13,137	1,314	10	1,314	0	3,285	50
51	New Fire Sprinkler Installation in Boiler Room	2013	5,750	575	10	575		1,438	51
52	R/M Reclass: Heat Pump & Blower-Hallway 1 (Dining RM & Kitcl	2013	2,695		10	270	270	675	52
53	R/M Reclass: Garcia Masonry	2013	3,800		10	380	380	950	53
54									54
55	R/M Reclass: Guttering, corners, fascia & downspouts for bldg	2014	2,870		10	287	287	431	55
56	R/M Reclass: Building HVAC unit controls	2014	2,640		5	528	528	792	56
57	R/M Reclass: EMCOR-Replace Fan (HP#5); replace compressor	2014	5,230		5	1,046	1,046	1,569	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	821	821	1,232	59
60	motor on the hall unit						#VALUE!		60
61	R/M Reclass: Generator repair- Rear of building	2014	2,547		5	509	509	764	61
62	R/M Reclass: Repair of boiler & heat pump in kitchen, admin	2014	4,098		5	820	820	1,230	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	2,708	65
66	RF Technologies - Wanderer system	2014	17,335		5	3,467	3,467	5,201	66
67	D Construction inv 22294 - Driveway extension	2014	21,075	2,634	8	2,634	(0)	3,951	67
68	R/M Reclass: EMCOR-Replace compressor-Mech rm.-Inspect	2014	5,220		5	1,044	1,044	1,566	68
69	& evaluate 45 heat pumps-Replace/Repair where necessary								69
70	TOTAL (lines 4 thru 69)		$ 404,678	$ 13,208		$ 45,579	$ #VALUE!	$ 191,386	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: 01/01/2015 Ending: 12/31/2015

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	$ 13,208		$ 45,579	$ 32,371	$ 191,386	1
2									2
3	Replacement of failed coil for the fluid cooler in the cooling tower	2015	53,850		10	2,693	2,693	2,693	3
4	R/M Reclass: EMCOR-Inspect & evaluate 11 heat pumps.	2015	3,633		5	363	363	363	4
5	Replace/Repair where necessary. Mechanical Room.								5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 462,161	$ 13,208		$ 48,635	$ 35,426	$ 194,441	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: 01/01/2015 Ending: 12/31/2015

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	$ 204,809	$ 30,736	$ 29,741	$ (995)	5-7	$ 124,275	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	20,170					20,170	73
74	Home Office Allocation			4,400	4,400			74
75	TOTALS	$ 224,979	$ 30,736	$ 34,141	$ 3,405		$ 144,445	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	$ 1,575	$ 788	$ (788)	4	$ 788	76
77	Facility Use	02 Dodge Van	2015	5,183	56	648	592	4	648	77
78										78
79										79
80	TOTALS			$ 11,483	$ 1,631	$ 1,435	$ (196)		$ 1,435	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)	$	698,623	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	45,575	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	84,211	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	38,636	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	340,322	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wakefield Communities-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. [X] 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	$ 713091.60			3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 713,092 **			7

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

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 3/26/10
    Ending 3/31/2025

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2016	$ 734,000
13.	12/31/2017	$ 756,000
14.	12/31/2018	$ 778,000

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: $ 44,251 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

* 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: **12/31/2015**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Equipment Rental-Maint	16,600
Equipment Rental-Nurse	18,364
Equipment Rental-Dietary	1,457
Equipment Rental-Admin	252
Other Rent/Lease Expense	3,358
Home Office Allocation	4,220
Total - Line 16	**44,251**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	39(2) &(3)	hrs	$	4,965	$ 228,377	$ 140	4,965	$ 228,517	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,578	81,820		1,578	81,820	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2) &(3)	hrs		4,710	264,531	2,417	4,710	266,948	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				332,766		332,766	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(2) & (3)				1,671	20,933		22,604	12
13	Other (specify):									13
14	TOTAL			$	11,253	$ 576,399	$ 356,256	11,253	$ 932,655	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 Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 39,872	$ 39,872	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 193,255)	1,450,756	1,450,756	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	101,728	101,728	7
8	Accounts Receivable (owners or related parties)	520,856	520,856	8
9	Other(specify): Other Rec - See Sch 17A	627,625	627,625	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,740,837	$ 2,740,837	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	143,261	462,161	15
16	Equipment, at Historical Cost	292,999	236,462	16
17	Accumulated Depreciation (book methods)	(213,219)	(340,322)	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 (spe CIP	53,850		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 276,890	$ 358,300	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,017,727	$ 3,099,137	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 516,308	$ 516,308	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,670	26,670	28
29	Short-Term Notes Payable	(0)	(0)	29
30	Accrued Salaries Payable	175,807	175,807	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,000	84,000	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	145,629	145,629	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 948,413	$ 948,413	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 948,413	$ 948,413	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,069,313	$ 2,150,723	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,017,727	$ 3,099,137	48

***(See instructions.)**

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description		Operating	After Consolidation
	153000	247,950	247,950
	153500	256,968	256,968
	161000	26,670	26,670
	261000	35,680	35,680
	263000	88	88
	313100	54,250	54,250
	319800	392	392
	319875	3,800	3,800
	319880	1,827	1,827
Total - Line 9		**627,625**	**627,625**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description		Operating	After Consolidation
	37000	8,269	8,269
	313103	117	117
	319850	5,536	5,536
	332010	77,119	77,119
	337000	54,588	54,588
Total - Line 36		**145,629**	**145,629**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,111,700	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,111,700	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(42,386)	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)**	$ (42,386)	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)**	$ 2,069,313	24 *

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,524,105	1
2	Discounts and Allowances for all Levels	(2,490,807)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,033,299	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,940,562	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,940,562	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	351,314	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,560	19
20	Radiology and X-Ray	7,798	20
21	Other Medical Services	82,839	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 448,511	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue	4,646	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,646	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,427,077	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,194	31
32	Health Care	1,974,850	32
33	General Administration	1,498,013	33
	B. Capital Expense		
34	Ownership	880,056	34
	C. Ancillary Expense		
35	Special Cost Centers	1,058,866	35
36	Provider Participation Fee	184,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,469,463	40
41	**Income before Income Taxes (line 30 minus line 40)****	(42,386)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (42,386)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,696,129	44
45	Private Pay - Net Inpatient Revenue	1,090,608	45
46	Medicare - Net Inpatient Revenue	(893,431)	46
47	Other-(specify) Managed Care	(97,423)	47
48	Other-(specify) Hospice	237,416	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,033,299	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,982	2,026	$ 60,627	$ 29.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,708	14,573	365,873	25.11	3
4	Licensed Practical Nurses	17,913	19,008	425,650	22.39	4
5	CNAs & Orderlies	61,724	65,822	722,224	10.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,116	5,394	56,135	10.41	10
11	Social Service Workers	4,065	4,371	68,585	15.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,285	16,036	165,239	10.30	15
16	Dishwashers					16
17	Maintenance Workers	3,347	3,637	50,829	13.98	17
18	Housekeepers	13,032	13,914	135,713	9.75	18
19	Laundry	4,462	4,820	39,765	8.25	19
20	Administrator	2,080	2,080	88,854	42.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,623	6,029	91,634	15.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,263	1,292	16,637	12.88	31
32	Other Health CSee Sch 20A	2,933	3,340	79,356	23.76	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,533	162,342	$ 2,367,121 *	$ 14.58	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	173	$ 8,574	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Flat Rate	3,238	10(3)	37
38	Nurse Consultant	103	13,357	10(3)	38
39	Pharmacist Consultant	Flat Rate	6,671	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Flat Rate	1,653	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,700	11(3)	44
45	Social Service Consultant	12	780	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	334	$ 54,973		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	48	$ 1,867	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	48	$ 1,867		53

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2015**

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
Nursing Admin	2,081	2,154	39,964	$ 18.55
MDS Corrdinator	852	1,186	39,392	$ 33.21
Total - Line 32 Other Health Care (specify):	**2,933**	**3,340**	**79,356**	**$ 23.76**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Wood (1/1 - 7/14/15)	Administrator	0	$ 44,246
Carolyn Progress (7/28 - 12/31/15)	Administrator	0	44,608
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,854

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Col #7	$ 321,354
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 321,354

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C	See Sch 21C	$ 56,302
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 56,302

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,925
Unemployment Compensation Insurance	92,798
FICA Taxes	181,086
Employee Health Insurance	64,253
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	179,029
TOTAL (agree to Schedule V, line 22, col.8)	$ 637,091

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,105
Health Care Worker Background Check	1,355
(Indicate # of checks performed 136)	
Patient Background Checks 136	1,355
Miscellaneous Licenses & Fees	4,850
Misc. Publications & Subscriptions	5,176
Management company allocation	749
Miscellaneous Dues	2,473
Lobbying	(490)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,573

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,749
Non-Allowable Meals & Entertainment	(1,669)
Seminar Expense	5,074
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,154

**See instructions.

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Brian LaLonde, CPA	Accounting	1,925
McGladrey LLP	Accounting	7,775
Rue & Associates	Accounting	1,855
WW Healthcare Consultants	Legal	89
O'Hagan Spencer, LLC	Legal	1,755
Polsinelli Shughart	Legal	1,550
Malmquist & Geiger	Legal Collections	4,155
Matrixcare SDS-1	Data Processing	(2,081)
Medifax-EDI, LLC	Data Processing	92
Wescom Solutions	Data Processing	18,936
Paylocity	Payroll Processing	20,251
	Total (agree to Schedule V, line 19, column 3)	56,302
Allocated from Management Company	Legal Fees	2,675
Allocated from Management Company	Professional Services	2,104
Less: Non-Allowable Legal Fees		(4,155)
	Total (agree to Schedule V, line 19, column 8)	56,926

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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													N/A
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 1,300**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,060** 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. $ **184,484**
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. $ **N/A** 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? **Yes - Minimal trips to Home Office**
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?
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 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.