

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0045476</u></p> <p>Facility Name: <u>Red Bud Regional Care</u></p> <p>Address: <u>350 W South First St</u> <u>Red Bud</u> <u>62278</u> Number City Zip Code</p> <p>County: <u>Randolph</u></p> <p>Telephone Number: <u>618 282 3831</u> Fax # <u>618028204070</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/1/01</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2015</u> to <u>06/30/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 150px; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Zachary D. Schmidt</u> (Date) _____</td> </tr> <tr> <td rowspan="4" style="width: 150px; vertical-align: top;">Paid Preparer</td> <td>(Title) <u>CFO</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Zachary D. Schmidt</u> (Date) _____	Paid Preparer	(Title) <u>CFO</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Firm Name & Address) _____																																				
	(Telephone) () _____ Fax # () _____																																				
<p>In the event there are further questions about this report, please contact: Name: <u>Mark Shrouf</u> Telephone Number: <u>(615) 221-3660</u> Email Address: _____</p>	<p>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</p>																																				

Facility Name & ID Number Red Bud Regional Care

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	42,090	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	7

B. Census-For the entire report period.

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

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

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 9/1/2011

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

YES Date 9/1/2001 NO

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

YES NO If YES, enter number of beds certified 115 and days of care provided 1,625

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 6/30/16

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

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

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

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

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Red Bud Regional Care

#0045476

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

V. COST CENTER EXPENSES (continued)

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

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(282)	1		4
5	Telephone, TV & Radio in Resident Rooms	(9,549)	35		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,831)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,831)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Red Bud Regional Care

ID# 0045476

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Red Bud Regional Care# 0045476

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(282)	806,504	0	0	0	0	0	0	0	0	0	806,222	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	11,731	0	0	0	0	0	0	0	0	0	11,731	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	39,912	0	0	0	0	0	0	0	0	0	39,912	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(282)	858,147	0	0	0	0	0	0	0	0	0	857,865	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	43,042	0	0	0	0	0	0	0	0	0	43,042	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	43,042	0	0	0	0	0	0	0	0	0	43,042	16
	C. General Administration													
17	Administrative	0	101,874	0	0	0	0	0	0	0	0	0	101,874	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	38,994	0	0	0	0	0	0	0	0	0	38,994	22
23	Inservice Training & Education	0	23,469	0	0	0	0	0	0	0	0	0	23,469	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	164,337	0	0	0	0	0	0	0	0	0	164,337	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(282)	1,065,526	0	0	0	0	0	0	0	0	0	1,065,244	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(9,549)	0	0	0	0	0	0	0	0	0	0	(9,549)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,549)	0	0	0	0	0	0	0	0	0	0	(9,549)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,831)	1,065,526	0	0	0	0	0	0	0	0	0	1,055,695	45

VII. RELATED PARTIES

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

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

07/01/2015

Ending:

06/30/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

07/01/2015

Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Red Bud Regional Care

0045476

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$			\$							
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$							
15	TOTALS (line 9+line14)						\$	\$			\$							

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.

\$ **18,726** 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **18,726** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ 3

4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	51,553	8
	2012	53,813	9
	2013	54,370	10
	2014	54,625	11
	2015	53,959	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Red Bud Regional Care COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0045476

CONTACT PERSON REGARDING THIS REPORT Mark ShROUT

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

Blank lines for listing other business entities.

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

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Carpeting for Nursing Home	1996		2,887		5			2,887	9
10		Fire Doors	1996		1,935	97	20	97	0	1,912	10
11		Grab Bars	1996		90	5	20	5		90	11
12		Renovation of East Wing Nurses' Station	1996		20,850		15			20,850	12
13		Renovation of Patient Room 105	1996		4,500		15			4,500	13
14		Renovation of West Wing Nurses' Station	1996		20,850		15			20,850	14
15		Reseal Parking Lot	1996		1,472		2			1,472	15
16		Roof Replacement	1996		99,865		10			99,865	16
17		Sandblast Entrance Sign	1996		1,750		10			1,750	17
18		Signs and Installation	1996		579		5			579	18
19		Wiring of East and West Wing Nurses' Station	1996		25,040	1,252	20	1,252		24,518	19
20		Final Landscaping	1996		2,350		10			2,350	20
21		Additional Renovations	1997		1,399	70	20	70		1,318	21
22		Laundry Renovation	1997		42,244	2,112	20	2,112		41,187	22
23		Hand rail	1998		3,042		10			3,042	23
24		Renovation of Patient Rooms and Corridors	1998		464,732	23,237	20	23,237		418,261	24
25		Schaefer Water Softener	1998		8,079		10			8,079	25
26		Vinyl Overlay	1998		1,998		10			1,998	26
27		West Corridor Floor Replacement	1998		6,000		10			6,000	27
28		Boiler Feed Pump	1999		1,601		10			1,601	28
29		Carpeting and Paint	1999		1,130		5			1,130	29
30		Room Remodel	1999		750	38	20	38		658	30
31		Additional Hardware	2000		55		10			55	31
32		Signage - Paint & Reletter Nursing Home Sign	2002		1,244		10			1,244	32
33		Carrier - Chiller 100 Ton	2003		75,360		12			75,360	33
34		Code Alert Wanderer System	2003		7,970		8			7,970	34
35		Keypad for Nursing Home Doors	2003		2,138		15			1,724	35
36		Wanderguard System	2004		40,438		10			40,348	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Red Bud Regional Care# 0045476

Report Period Beginning:

07/01/2015 Ending: 06/30/2016**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler - Lockinavar	2005	\$ 12,936	\$ 719	18	\$ 719	\$	\$ 8,266	37
38	Carpeting for Nursing Home	2005	7,503		5			7,503	38
39	Fire Alarm - Code Renovations for Nursing Home	2008	4,768	477	10	477		3,616	39
40	Fire Alarm - Electrical Work	2008	4,650	465	10	465		3,538	40
41	Canopy - Nursing Home Entrance	2008	5,998	400	15	400		3,233	41
42	Nursing Home Code Repairs - Construction Fees	2008	127,187	8,479	15	8,479		64,299	42
43	Nursing Home Code Repairs - Curtains	2008	19,199		5			19,199	43
44	Carpet - Fron Office & Center Office Areas	2008	7,566		5			7,566	44
45	Landscaping	2009	3,345	335	10	335		2,260	45
46	Capitalized Interest for CIP	2009	2,846	114	25	114		854	46
47	Electrical Work Add-ons to Generators	2009	23,650	2,365	10	2,365		17,146	47
48	Flooring - Removal of Tiles in 20 Patient Rooms	2009	18,000		5			18,000	48
49	Flooring, Tile for 20 Patient Rooms	2009	33,400	3,340	10	3,340		24,076	49
50	Canopy for Resident Patio	2009	1,163	78	15	78		558	50
51	Valances for Windows in Resident Rooms	2009	3,208		5			3,208	51
52	Emergency Generator	2010	22,556	1,128	20	1,128		6,861	52
53	Emergency Generator - Electrical Work	2010	12,250	613	20	613		3,728	53
54	Capitalized Interest for CIP	2011	6,604	264	25	264		1,584	54
55	Electrical Work - Receptacles for Floor Removal	2011	3,225	215	15	215		1,236	55
56	Electrical Work - NH Renovations	2011	64,037	4,269	15	4,269		24,547	56
57	Flooring - NH Renovations	2011	178,640	17,864	10	17,864		102,718	57
58	Asbestos Monitoring - west wing, east wing, hallway	2011	11,352	757	15	757		4,352	58
59	Flooring - Plank 2 med room, 2 utility room, 2 clean linen room	2011	2,430	243	10	243		1,397	59
60	Flooring - Rubber Floor and Plank 4 shower rooms, 4 soiled rooms	2011	14,740	1,474	10	1,474		8,475	60
61	Flooring - Plank and Non-slip VCT physical therapy, dining room, and D	2011	13,654	1,365	10	1,365		7,849	61
62	Asbestos Removal - patient rooms hallways and common areas	2011	80,000	5,333	10	5,333		30,665	62
63	Sprinkler System Upgrade - NH	2011	19,454	1,297	15	1,297		7,782	63
64	Sign - care center entrance	2012	5,057	140	15	140		574	64
65	Capitalized Interest for CIP	2012	2,178	43	25	43		215	65
66	Stucco and painting nursing home building	2011	27,500	4,583	5	4,583		22,915	66
67	cabinets - kitchenette	2011	963	32	15	32		160	67
68	cabinets - kitchenette	2011	964	32	15	32		160	68
69	countertops - kitchenette	2011	767	25	15	25		125	69
70	TOTAL (lines 4 thru 69)		\$ 1,582,139	\$ 83,259		\$ 83,260	\$ 0	\$ 1,200,263	70

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

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,063,766	\$ 105,958		\$ 105,958	\$ 0	\$ 1,284,526	1
2	2013	2,112	82	15	82		164	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,065,878	\$ 106,040		\$ 106,040	\$ 0	\$ 1,284,690	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,004,214	\$ 68,905	\$ 68,905	\$		\$ 706,945	71
72	Current Year Purchases	(28,384)					(65,304)	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 975,830	\$ 68,905	\$ 68,905	\$		\$ 641,641	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 3,041,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,945	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,945	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,926,331	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: 07/01/2015

Ending: 06/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 19,516 Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		248		248
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 248	\$	\$ 248
10	SUM OF line 9, col. 1 and 2 (e)	\$	248		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/1	1577.25 hrs	\$ 58,127		\$	\$	1,577	\$ 58,127	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/1	734.5 hrs	29,704				735	29,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 87,831		\$	\$	2,312	\$ 87,831	14

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2016

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (20,959)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	770,466		3
4	Supply Inventory (priced at)	5,914		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,070		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 765,491	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	12,747		13
14	Buildings, at Historical Cost	347,891		14
15	Leasehold Improvements, at Historical Cost	996,400		15
16	Equipment, at Historical Cost	900,282		16
17	Accumulated Depreciation (book methods)	(1,129,407)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,663		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,129,576	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,895,067	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,987	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,495		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,332		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued liabilities</u>	219,940		36
37	<u>Due from (to) related party</u>	18,357		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 511,111	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 511,111	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,383,956	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,895,067	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,797,970	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,797,970	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(414,014)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (414,014)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,383,956	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,363,038	1
2	Discounts and Allowances for all Levels	(695,719)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,667,319	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,911	13
14	Non-Patient Meals	282	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,193	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,686,512	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services		31
32	Health Care		32
33	General Administration	4,958,853	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,958,853	40
41	Income before Income Taxes (line 30 minus line 40)**	(272,341)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (272,341)	43

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Red Bud Regional Care

0045476

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,454	1,606	\$ 64,734	\$ 40.31	1
2	Assistant Director of Nursing	2,112	2,184	72,544	33.22	2
3	Registered Nurses	10,975	11,706	317,783	27.15	3
4	Licensed Practical Nurses	27,181	29,680	641,876	21.63	4
5	CNAs & Orderlies	66,593	70,419	983,887	13.97	5
6	CNA Trainees					6
7	Licensed Therapist	4,054	4,474	135,883	30.37	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,859	2,122	29,941	14.11	9
10	Activity Assistants	2,148	2,385	25,608	10.74	10
11	Social Service Workers	3,515	3,956	44,783	11.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	472	472	6,960	14.75	17
18	Housekeepers	8,455	9,857	105,211	10.67	18
19	Laundry	3,160	3,762	42,687	11.35	19
20	Administrator	1,660	1,840	58,381	31.73	20
21	Assistant Administrator					21
22	Other Administrative	843	843	36,194	42.93	22
23	Office Manager					23
24	Clerical	2,084	2,401	39,214	16.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,959	2,116	26,331	12.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,524	149,823	\$ 2,632,017 *	\$ 17.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	29	9,600	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,766	10/3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	352	22,896	10a/3	43
44	Activity Consultant	37	2,489	11/3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	418	\$ 37,751		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 159,540	IDPH License Fee	\$	
				Unemployment Compensation Insurance	25,874	Advertising: Employee Recruitment		
				FICA Taxes	190,850	Health Care Worker Background Check		
				Employee Health Insurance	380,280	(Indicate # of checks performed <u>49</u>)	2,510	
				Employee Meals		Patient Background Checks <u>95</u>	1,520	
				Illinois Municipal Retirement Fund (IMRF)*				
				Retirement Plan	15,328			
				Life Insurance	1,787			
				Other	1,019			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,030		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Barber/Beauty Shop			\$ 17,188				Yellow page advertising ()	
Fingerprints			35				TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 17,223	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
			\$			\$	\$	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL			\$	
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$1,990
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,754 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 240,922
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (282)
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 1.6
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees