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.

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

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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 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	45,018	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	45,018	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	10,875	11,133	6,406	28,414	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,875	11,133	6,406	28,414	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.12%

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 123 and days of care provided 5,166

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	207,765	38,342	14,501	260,608		260,608		260,608			1
2	Food Purchase		194,004		194,004		194,004		194,004			2
3	Housekeeping	84,474	30,942	75,175	190,591		190,591		190,591			3
4	Laundry	23,268	3,502	52,246	79,016		79,016		79,016			4
5	Heat and Other Utilities			85,968	85,968		85,968	2,162	88,130			5
6	Maintenance	55,486	25,124	164,325	244,935		244,935	(15,927)	229,008			6
7	Other (specify):*											7
8	TOTAL General Services	370,993	291,914	392,215	1,055,122		1,055,122	(13,765)	1,041,357			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,755,330	137,588	24,659	1,917,577		1,917,577		1,917,577			10
10a	Therapy											10a
11	Activities	64,865	2,108	2,774	69,747		69,747		69,747			11
12	Social Services	72,399			72,399		72,399		72,399			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,892,594	139,696	45,433	2,077,723		2,077,723		2,077,723			16
	C. General Administration											
17	Administrative	87,986		340,743	428,729		428,729	(340,743)	87,986			17
18	Directors Fees											18
19	Professional Services			71,020	71,020		71,020	10,349	81,369			19
20	Dues, Fees, Subscriptions & Promotions			14,762	14,762		14,762	(643)	14,119			20
21	Clerical & General Office Expenses	109,545	38,508	19,197	167,250		167,250	203,002	370,252			21
22	Employee Benefits & Payroll Taxes			689,062	689,062		689,062		689,062			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,047	2,047		2,047	4,375	6,422			24
25	Other Admin. Staff Transportation			21,765	21,765		21,765	(2,108)	19,657			25
26	Insurance-Prop.Liab.Malpractice			127,220	127,220		127,220	550	127,770			26
27	Other (specify):* HO Alloc - Benefits							28,727	28,727			27
28	TOTAL General Administration	197,531	38,508	1,285,816	1,521,855		1,521,855	(96,491)	1,425,364			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,461,118	470,118	1,723,464	4,654,700		4,654,700	(110,256)	4,544,444			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: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			51,528	51,528		51,528	46,365	97,893			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28	28		28	32,731	32,759			32
33	Real Estate Taxes			88,000	88,000		88,000	4,635	92,635			33
34	Rent-Facility & Grounds			714,270	714,270		714,270		714,270			34
35	Rent-Equipment & Vehicles			42,933	42,933		42,933	3,183	46,116			35
36	Other (specify):*											36
37	**TOTAL Ownership**			896,759	896,759		896,759	86,914	983,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		374,896	530,497	905,393		905,393		905,393			39
40	Barber and Beauty Shops			529	529		529		529			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,622	205,622		205,622		205,622			42
43	Other (specify):* Non-Allowable Cos			228,524	228,524		228,524	(228,524)				43
44	**TOTAL Special Cost Centers**		374,896	965,172	1,340,068		1,340,068	(228,524)	1,111,544			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,461,118	845,014	3,585,395	6,891,527		6,891,527	(251,866)	6,639,661			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: 01/01/2016 Ending: 12/31/2016

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	(6,841)	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	41,178	30		9
10	Interest and Other Investment Income	(67)	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	(824)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,980)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(180,000)	43		24
25	Fund Raising, Advertising and Promotional	(14,015)	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	(43,960)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (208,509)		$	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)	(43,357)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (43,357)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (251,866)		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology	$ (9,879)	43	1
2	Laboratory	(16,965)	43	2
3	Capitalize Repairs Expenses	(17,924)	6	3
4	Disallow Rotary Club & Chamber of Commerce Dues	(670)	20	4
5	Other Revenue offset	(1,176)	21	5
6	Lobbying	(1,981)	20	6
7	Real Estate Tax	4,635	33	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**	(43,960)		49

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.
		Regency Care of Silver Spring, LLC	Silver Spring, MD	WW Healthcare Consu	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: 01/01/2016 Ending: 12/31/2016

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	100	$ 2,162	$ 2,162	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100	1,791	1,791	16
17	V	17	Management Fees	340,743	WW Healthcare Consultants, LLC	100		(340,743)	17
18	V	19	Professional Services		WW Healthcare Consultants, LLC	100	14,329	14,329	18
19	V	20	Dues, Fees, Subs. & Promotions		WW Healthcare Consultants, LLC	100	358	358	19
20	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100	164,435	164,435	20
21	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100	26,075	26,075	21
22	V	21	Salaries/Wages		WW Healthcare Consultants, LLC	100	15,317	15,317	22
23	V	24	Travel/Seminar		WW Healthcare Consultants, LLC	100	4,581	4,581	23
24	V	26	Insurance		WW Healthcare Consultants, LLC	100	550	550	24
25	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100	28,727	28,727	25
26	V	30	Depreciation		WW Healthcare Consultants, LLC	100	5,188	5,188	26
27	V	32	Interest		WW Healthcare Consultants, LLC	100	32,798	32,798	27
28	V	35	Rent		WW Healthcare Consultants, LLC	100	3,183	3,183	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			$ 340,743			$ 299,494	$ * (41,249)	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: 01/01/2016 Ending: 12/31/2016

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	$ 76,696	SCK Assurance, LLC		$ 76,696	$	15
16	V	26	Insurance - Gen & Prof Liability	61,449	SCK Assurance, LLC		61,449		16
17	V	26	Insurance - RAC Audit	17,355	SCK Assurance, LLC		17,355		17
18	V	26	Insurance - Health Insurance	50,503	SCK Assurance, LLC		50,503		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			$ 206,003			$ 206,003	$ * 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: 01/01/2016 Ending: 12/31/2016

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	25	Other Admin Staff Transportation	$ 14,756	DMG Aero		$ 12,648	$ (2,108)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,756			$ 12,648	$ * (2,108)	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: 01/01/2016 Ending: 12/31/2016

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Note: No owners received comensation from this facility.			0.00					$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [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	261,255	8	$ 19,880	$	28,414	$ 2,162	1
2	6	Maintenance & Repair - Other	Resident days	261,255	8	16,471		28,414	1,791	2
3	19	Professional Services	Resident days	261,255	8	131,749		28,414	14,329	3
4	20	Dues, Fees, Subs. & Promotions	Resident days	261,255	8	3,294		28,414	358	4
5	21	Clerical/General-Other	Resident days	261,255	8	1,511,915	1,511,915	28,414	164,435	5
6	21	Office/Other Supplies	Resident days	261,255	8	239,748		28,414	26,075	6
7	21	Salaries/Wages	Resident days	261,255	8	140,832		28,414	15,317	7
8	24	Travel/Seminar	Resident days	261,255	8	37,475		28,414	4,076	8
9	26	Insurance	Resident days	261,255	8	5,053		28,414	550	9
10	27	Employee Benefits	Resident days	261,255	8	264,130		28,414	28,727	10
11	30	Depreciation	Resident days	261,255	8	47,704		28,414	5,188	11
12	32	Interest	Resident days	261,255	8	301,566		28,414	32,798	12
13	35	Rent	Resident days	261,255	8	29,263		28,414	3,183	13
14	43	Other Costs	Resident days	261,255	8	4,643		28,414	505	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,753,723	$ 1,511,915		$ 299,494	25

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [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			$	$		$ 76,696	1
2	26	Insurance - Gen & Prof Liability	Direct Cost						61,449	2
3	26	Insurance - RAC Audit	Direct Cost						17,355	3
4	26	Insurance - Health Insurance	Direct Cost						50,503	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					$	$		$ 206,003	25

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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: DMG Aero
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	25	Other Admin Staff Transportation	Direct Cost			$	$		$ 12,648	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	TOTALS					$	$		$ 12,648	25

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11								Miscellaneous Interest Expenses			28	11
12								Interest Income			(67)	12
13								Allocated from Home Office			32,798	13
14	TOTAL Non-Facility Related						$	$			$ 32,759	14
15	TOTALS (line 9+line14)						$	$			$ 32,759	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:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 84000	1
	2015		
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.)		$ 88,635	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,635	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 88,000	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
	Alloc. Fr. Mgmt 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.		$ 92,635	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	90,177.60	8
	2012	85,918.00	9
	2013	85,457.00	10
	2014	83,359.00	11
	2015	88,635.00	12

Accrual Calculation: PY Accrual: $84,000
\+ CY RE Tax Expense: $88,635
\+ Immaterial Variance: $4,635
Total: $88,000

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 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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-33-301-013	Nursing Facility	$ 87,608.00	$ 87,608.00
2.	02-33-301-006	Nursing Facility	$ 594.54	$ 594.54
3.	02-33-353-025	Nursing Facility	$ 176.36	$ 176.36
4.	02-33-353-026	Nursing Facility	$ 256.24	$ 256.24
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,635.14	$ 88,635.14

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 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.

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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		5,040	11
12	Carpet			2009	3,183		5			3,183	12
13											13
14	New Wing Construction			2010	20,853	2,085	10	2,085		13,555	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		6,767	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		2,010	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		10,171	27
28	hallways, bathrooms & nursing station, pressure test										28
29											29
30	Hot Water Replacement			2010	4,800		10	480	480	3,120	30
31											31
32	HVAC and Sprinkler System throughout facility			2010	77,975		10	7,798	7,798	50,687	32
33	New Cooling Tower			2010	27,775		10	2,778	2,778	18,057	33
34	Renovate hallway and replace nursing station with private			2010	44,307		10	4,431	4,431	28,802	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Doors Done Right-6 Doors- Invoice 4563 4/8/2011	2011	$ 7,004	$	15	$ 467	$ 467	$ 2,568	37
38	RF Technologies-Wanderer System	2011	9,531		5	953	953	9,531	38
39	Illinois Electric Services Inv 113009336,113011336,113014336 Elec	2011	9,350	935	10	935		5,143	39
40	Illinois Electric Services - Install code alert model	2011	7,300		7	1,043	1,043	5,735	40
41	Menards - BTU Window AC & Stand fan	2011	3,119		10	312	312	1,716	41
42	Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638		10	364	364	2,001	42
43									43
44	Sprinkler System - Nursing Home	2012	10,326	1,033	10	1,033	0	4,647	44
45	New Door Installation - Employee Entrance & Service Hall	2012	6,330	633	10	633	(0)	2,849	45
46	R/M Reclass: Chiller Condenser (outside, service entrance)	2012	2,762		5	552	552	2,486	46
47	Equipment Reclass: Generator (outside, off large dining rm.)	2012	4,617		5	923	923	4,155	47
48									48
49	Heat Pump Installation in Hallway One	2013	7,513	412	10	751	339	2,629	49
50	New Door Installation - Nursing Home	2013	13,137	1,314	10	1,314	0	4,599	50
51	New Fire Sprinkler Installation in Boiler Room	2013	5,750	575	10	575		2,013	51
52	R/M Reclass: Heat Pump & Blower-Hallway 1 (Dining RM & Kitc	2013	2,695		10	270	270	945	52
53	R/M Reclass: Garcia Masonry	2013	3,800		10	380	380	1,330	53
54									54
55	R/M Reclass: Guttering, corners, fascia & downspouts for bldg	2014	2,870		10	287	287	718	55
56	R/M Reclass: Building HVAC unit controls	2014	2,640		5	528	528	1,320	56
57	R/M Reclass: EMCOR-Replace Fan (HP#5); replace compressor	2014	5,230		5	1,046	1,046	2,615	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	2,053	59
60	motor on the hall unit								60
61	R/M Reclass: Generator repair- Rear of building	2014	2,547		5	509	509	1,274	61
62	R/M Reclass: Repair of boiler & heat pump in kitchen, admin	2014	4,098		5	820	820	2,049	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	4,513	65
66	RF Technologies - Wanderer system	2014	17,335		5	3,467	3,467	8,668	66
67	D Construction inv 22294 - Driveway extension	2014	21,075	2,634	8	2,634	(0)	6,586	67
68	R/M Reclass: EMCOR-Replace compressor-Mech rm.-Inspect	2014	5,220		5	1,044	1,044	2,610	68
69	& evaluate 45 heat pumps-Replace/Repair where necessary								69
70	TOTAL (lines 4 thru 69)		$ 404,678	$ 13,208		$ 44,626	$ 31,418	$ 236,011	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: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 404,678	$ 13,208		$ 44,626	$ 31,418	$ 236,011	1
2									2
3	Replacement of failed coil for the fluid cooler in the cooling tower	2015	53,850		10	5,385	5,385	8,078	3
4	R/M Reclass: EMCOR-Inspect & evaluate 11 heat pumps.	2015	3,633		5	727	727	1,090	4
5	Replace/Repair where necessary. Mechanical Room.								5
6									6
7	Walk-In Cooler. Kitchen	2016	7,366	488	15	246	(242)	246	7
8	Hot Water Heater. Mechanical Room	2016	8,086	783	10	404	(379)	404	8
9	5 Comfort Aire Heat Pumps	2016	24,785	147	10	1,239	1,092	1,239	9
10	Goldy Lock Door Replacement	2016	12,271	696	15	409	(287)	409	10
11	Air Cooled Chillder for HVAC. Mechanical Room	2016	51,800	1,736	15	1,727	(9)	1,727	11
12	Coil System. Mechical Room	2016	53,850	1,496	15	1,795	299	1,795	12
13	Flow Meters for Heat Pumps	2016	22,262	742	10	1,113	371	1,113	13
14	Turn Around in Front Building	2016	5,000	140	10	250	110	250	14
15	R&M Reclass: Replace pipe in fire system. Throughout Building	2016	17,924		25	358.48	358	358	15
16									16
17									17
18									18
19	Adjustment to Current Book Depreciation			(3,328)			3,328		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)		$ 665,505	$ 16,107		$ 58,279	$ 42,171	$ 252,720	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: 01/01/2016 Ending: 12/31/2016

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	$ 154,016	71
72	Current Year Purchases	14,296	1,814	1,814	-	5	1,814	72
73	Fully Depreciated Assets	20,170			-		20,170	73
74	Home Office Allocation			5,188	5,188			74
75	TOTALS	$ 239,275	$ 32,550	$ 36,743	$ 4,193		$ 176,000	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	$ 1,575	$ -	4	$ 2,363	76
77	Facility Use	02 Dodge Van	2015	5,183	1,296	1,296	-	4	1,944	77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 11,483	$ 2,871	$ 2,871	$ -		$ 4,307	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)	$ 916,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 97,893	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 46,364	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 433,027	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: 01/01/2016 Ending: 12/31/2016

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	$ 714270			3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 714,270 **			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.	/2017	$ 756000
13.	/2018	$ 778000
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 46,116 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: **12/31/2016**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Equipment Rental - Maintenance	$ 18,672
Equipment Rental - Nurse	$ 20,055
Equipment Rental - Dietary	$ 882
DT - Equipment Rental	$ 147
Other Rent/Lease Equipment	$ 3,177
Home Office Allocation	$ 3,183
Total - Line 16	**$ 46,116**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$	3,906	$ 179,669	$	3,906	$ 179,669	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,759	91,209		1,759	91,209	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2) &(3)	hrs		4,587	257,591	311	4,587	257,902	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				350,338		350,338	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)				2,028			2,028	12
13	Other (specify): Oxygen	39(2)					24,247		24,247	13
14	TOTAL			$	10,252	$ 530,497	$ 374,896	10,252	$ 905,393	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: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 148,400	$ 148,400	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 274,616)	2,561,830	2,561,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	99,752	99,752	7
8	Accounts Receivable (owners or related parties)	509,065	509,065	8
9	Other(specify): Oth Curr Assets - See Sch 17A	572,308	572,308	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,891,355	$ 3,891,355	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	288,444	665,505	15
16	Equipment, at Historical Cost	347,531	250,758	16
17	Accumulated Depreciation (book methods)	(264,747)	(433,027)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 371,228	$ 483,236	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,262,583	$ 4,374,591	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,623,784	$ 1,623,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,628	22,628	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	208,312	208,312	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,000	88,000	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	332,828	332,828	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,275,552	$ 2,275,552	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)**	$ 2,275,552	$ 2,275,552	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,987,031	$ 2,099,039	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,262,583	$ 4,374,591	48

***(See instructions.)**

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2016**

Schedule 17A

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

Description	Operating	After Consolidation
Real Estate Tax Escrow	302,386	302,386
Capital Improvements Escrow	168,687	168,687
Resident Trust Cash	22,628	22,628
Deposits - Utilities	8,579	8,579
W/H Group Insurance	55,177	55,177
W/H Employee Advances	1,175	1,175
Due/To From SCK	7,725	7,725
Due/TO From IDA	5,951	5,951
Total - Line 9	**572,308**	**572,308**

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

Description	Operating	After Consolidation
Suspense	50,166	50,166
Health Savings Account	78	78
Due To/From Employee Health Ins	6,532	6,532
Escrows Payable to Wakefield	77,119	77,119
Reserve for Mcaid/Mcare Audit	51,038	51,038
Retro Revenue Reserve	147,895	147,895
Total - Line 36	**332,828**	**332,828**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,069,313	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(5,615)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,063,698	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(76,667)	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)**	$ (76,667)	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)**	$ 1,987,031	24 *

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

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,089,751	1
2	Discounts and Allowances for all Levels	(2,507,477)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,582,274	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,540,553	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,540,553	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	566,356	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,715	19
20	Radiology and X-Ray	9,641	20
21	Other Medical Services	102,078	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 690,790	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 67	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue	1,176	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,176	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,814,860	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,055,122	31
32	Health Care	2,077,723	32
33	General Administration	1,521,855	33
	B. Capital Expense		
34	Ownership	896,759	34
	C. Ancillary Expense		
35	Special Cost Centers	1,134,446	35
36	Provider Participation Fee	205,622	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,891,527	40
41	**Income before Income Taxes (line 30 minus line 40)****	(76,667)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (76,667)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,660,900	44
45	Private Pay - Net Inpatient Revenue	1,967,195	45
46	Medicare - Net Inpatient Revenue	(894,651)	46
47	Other-(specify) Managed Care	(259,917)	47
48	Other-(specify) Hospice	108,747	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,582,274	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: 01/01/2016 Ending: 12/31/2016

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	1,872	1,912	$ 56,578	$ 29.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,930	18,753	375,376	20.02	3
4	Licensed Practical Nurses	15,510	16,824	357,979	21.28	4
5	CNAs & Orderlies	66,156	70,471	828,127	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,868	5,966	64,865	10.87	10
11	Social Service Workers	4,120	4,142	72,399	17.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,282	18,402	207,765	11.29	15
16	Dishwashers					16
17	Maintenance Workers	3,409	3,573	55,486	15.53	17
18	Housekeepers	8,783	8,783	84,474	9.62	18
19	Laundry	2,520	2,520	23,268	9.23	19
20	Administrator	2,080	2,080	87,986	42.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,368	7,578	109,545	14.46	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	1,144	1,189	15,317	12.88	31
32	Other Health CSee Sch 20A	2,511	2,551	121,953	47.81	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,553	164,744	$ 2,461,118 *	$ 14.94	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	236	$ 11,701	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Flat Rate	2,594	10(3)	37
38	Nurse Consultant	57	7,383	10(3)	38
39	Pharmacist Consultant	Flat Rate	6,292	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,980	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	327	$ 47,950		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	39	860	10(3)	51
52	Certified Nurse Assistants/Aides	233	4,364	10(3)	52
53	TOTAL (lines 50 - 52)	272	$ 5,224		53

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2016**

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	320	320	65,049	$ 203.28
MDS Coordinator	2,191	2,231	56,904	$ 25.51
Total - Line 32 Other Health Care (specify):	**2,511**	**2,551**	**121,953**	**$ 47.81**

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carolyn Progress	Administrator	0	$ 87,986
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,986

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Col #7	$ 340,743
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 340,743

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C	See Sch 21C	$ 71,020
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 71,020

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,875
Unemployment Compensation Insurance	89,212
FICA Taxes	188,276
Employee Health Insurance	98,240
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	163,459
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,062

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	2,529
Health Care Worker Background Check	825
(Indicate # of checks performed 83)	
Patient Background Checks 83	825
Miscellaneous Licenses & Fees	4,276
Miscellaneous Dues	2,273
Management company allocation	358
IHCA	5,014
Noallowable Dues	(1,981)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,119

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,841
Allocated From Home Office	4,581
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,422

**See instructions.

Facility Name: **Regency Care of Morris**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Brian LaLonde, CPA	Accounting	500
McGladrey LLP	Accounting	7,125
WW Healthcare Consultants	Legal	4,220
O'Hagan Spencer, LLC	Legal	2,943
Polsinelli Shughart	Legal	5,178
Malmquist & Geiger	Legal	2,263
Point Click Care	Data Processing	6,269
Wescom Solutions	Data Processing	24,496
Paylocity	Payroll Processing	18,026
	Total (agree to Schedule V, line 19, column 3)	71,020
Allocated from Management Company	Legal Fees	7,831
Allocated from Management Company	Professional Services	6,498
Less: Non-Allowable Legal Fees		(3,980)
	Total (agree to Schedule V, line 19, column 8)	81,369

Facility Name & ID Number Regency Care of Morris # 0050468 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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. **IHCA $5,014**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,226** 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. $ **205,622**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees