		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. **IDPH License ID Number:** 0045476

Facility Name: Red Bud Nursing Home

Address: 350 West South First Street
Number City Zip Code

County: Randolph

Telephone Number: 618 285 3831 **Fax #** 618 282 4070

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Lucie Green **Telephone Number:** 615-371-3747
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 07/01/2017 to 06/30/2018 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) Veronica Marin
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) 618-282-3831 Fax # ( )

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	41,975	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	41,975	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	13,053	13,435	2,345	28,833	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,053	13,435	2,345	28,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.69%

D. How many bed reserve days during this year were paid by the Department? _____ (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided _____

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 06/30/2018

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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			493,625	493,625		493,625	437,577	931,202			1
2	Food Purchase											2
3	Housekeeping	117,651	28,324	10,217	156,192		156,192		156,192			3
4	Laundry	46,728	5,535	109,380	161,643		161,643		161,643			4
5	Heat and Other Utilities											5
6	Maintenance	28,186		114,348	142,534		142,534	39,431	181,965			6
7	Other (specify):*											7
8	**TOTAL General Services**	192,566	33,859	727,569	953,994		953,994	477,008	1,431,002			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,563,793	34,877	303,391	2,902,061		2,902,061		2,902,061			10
10a	Therapy	227,611		18,509	246,120		246,120		246,120			10a
11	Activities											11
12	Social Services	78,175		8,969	87,144		87,144		87,144			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,869,579	34,877	330,869	3,235,325		3,235,325		3,235,325			16
	C. General Administration											
17	Administrative	160,185		161,020	321,205	(14,201)	307,004	283,914	590,918			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			7,453	7,453		7,453		7,453			20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			400,813	400,813		400,813	44,975	445,788			22
23	Inservice Training & Education							4,375	4,375			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,000	68,000		68,000		68,000			26
27	Other (specify):*											27
28	**TOTAL General Administration**	160,185		637,286	797,471	(14,201)	783,270	333,264	1,116,534			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,222,329	68,736	1,695,724	4,986,789	(14,201)	4,972,588	810,272	5,782,861			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 Nursing Home #0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			159,109	159,109		159,109	17,428	176,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,470	10,470		10,470		10,470			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,229	19,229		19,229	(11,247)	7,982			35
36	Other (specify):*											36
37	**TOTAL Ownership**			188,808	188,808		188,808	6,181	194,989			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					14,201	14,201		14,201			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,946	227,946		227,946		227,946			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			227,946	227,946	14,201	242,147		242,147			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,222,329	68,736	2,112,478	5,403,543		5,403,543	816,453	6,219,997			45

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(420)	1		4
5	Telephone, TV & Radio in Resident Rooms	(11,247)	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)**	$ (11,667)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,667)		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			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			14,201	17	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)**			$ 14,201		47

Red Bud Nursing Home

ID# 0045476

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

	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 Nursing Home **#** 0045476 **Report Period Beginning:** 07/01/2017 **Ending:** 06/30/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(420)	437,997	0	0	0	0	0	0	0	0	0	437,577	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	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	39,431	0	0	0	0	0	0	0	0	0	39,431	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(420)	477,428	0	0	0	0	0	0	0	0	0	477,008	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	283,914	0	0	0	0	0	0	0	0	0	283,914	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	44,975	0	0	0	0	0	0	0	0	0	44,975	22
23	Inservice Training & Education	0	4,375	0	0	0	0	0	0	0	0	0	4,375	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	333,264	0	0	0	0	0	0	0	0	0	333,264	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(420)	810,692	0	0	0	0	0	0	0	0	0	810,272	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Red Bud Nursing Home # 0045476 **Report Period Beginning:** 07/01/2017 **Ending:** 06/30/2018

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	17,428	0	0	0	0	0	0	0	0	0	17,428	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	(11,247)	0	0	0	0	0	0	0	0	0	0	(11,247)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(11,247)	17,428	0	0	0	0	0	0	0	0	0	6,181	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)**	(11,667)	828,120	0	0	0	0	0	0	0	0	0	816,453	45

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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
QHCCS, LLC	100			Red Bud Hospital	Red Bud	Hospital

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 493,625	Red Bud Hospital		$ 931,622	$ 437,997	1
2	V	10	Nursing and Medical Records		Red Bud Hospital				2
3	V	6	Maintenance		Red Bud Hospital		39,431	39,431	3
4	V	17	Administration		Red Bud Hospital		82,441	82,441	4
5	V	23	Education		Red Bud Hospital		4,375	4,375	5
6	V	22	Employee Benefits		Red Bud Hospital		44,975	44,975	6
7	V								7
8	V	30	Depreciation Expense		QHCCS,LLC		15,212	15,212	8
9	V	30	Depreciation Expense		QHCCS,LLC		2,216	2,216	9
10	V	17	Corporate Overhead		QHCCS,LLC		201,473	201,473	10
11	V								11
12	V								12
13	V								13
14	Total			$ 493,625			$ 1,321,745	$ * 828,120	14

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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 Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 6/30/2018

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: QHCCS, LLC
Street Address: 1573 Mallory Lane, STE 100
City / State / Zip Code: Brentwood, TN 37027
Phone Number: (615-371-3747
Fax Number: (615-371-4630

	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	30	Home Office Building Depr	Square Feet	6,113,281		$ 2,702,664	$	34,409	$ 15,212	1
2	30	Home Office Equipment Depr	Square Feet	6,113,281		393,868		34,409	2,217	2
3	17	Officer Salaries	Man Hours	22,294,396		3,004,587	3,004,587	148,676	20,037	3
4	17	Other Corp Salaries	Man Hours	22,294,396		17,614,151	17,614,151	148,676	117,465	4
5	17	Contract Labor	Contract Labor Exp	28,396,188		1,458,124		26,212	1,346	5
6	17	Corporate Benefits	Man Hours	22,294,396		3,506,624		148,676	23,385	6
7	17	Corporate Expenses	Accumulated Costs	###########		14,459,719		5,122,280	39,240	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					$ 43,139,737	$ 20,618,738		$ 218,902	25

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 10,470	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.)		$ 13,440	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,970	3
4. Real Estate Tax accrual used for 2018 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		$ 2,970	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	54,370	8
	2014	54,625	9
	2015	53,959	10
	2016	54,571	11
	2017	58,193	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Red Bud Nursing Home COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0045476

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-095-003-00	Attached	$ 58,193.00	$ 13,440.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,193.00	$ 13,440.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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).

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.

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting for Nursing Home			1996	2,887		5			2,887	9
10	Fire Doors			1996	1,935	23	20	23		1,935	10
11	Grab Bars			1996	90		20			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	522	20	522		25,040	19
20	Final Landscaping			1996	2,350		10			2,350	20
21	Additional Renovations			1997	1,399	11	20	11		1,399	21
22	Laundry Renovation			1997	42,244		20			42,244	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		441,498	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		696	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			2,138	35
36	Wanderguard System			2004	40,438		10			40,438	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 Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler - Lockinavar	2005	$ 12,936	$ 719	18	$ 719	$	$ 9,704	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		4,570	39
40	Fire Alarm - Electrical Work	2008	4,650	465	10	465		4,468	40
41	Canopy - Nursing Home Entrance	2008	5,998	400	15	400		4,033	41
42	Nursing Home Code Repairs - Construction Fees	2008	127,187	8,479	15	8,479		81,257	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		2,930	45
46	Capitalized Interest for CIP	2009	2,846	114	25	114		1,082	46
47	Electrical Work Add-ons to Generators	2009	23,650	2,365	10	2,365		21,876	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		30,756	49
50	Canopy for Resident Patio	2009	1,163	78	15	78		714	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		9,117	52
53	Emergency Generator - Electrical Work	2010	12,250	613	20	613		4,954	53
54	Capitalized Interest for CIP	2011	6,604	264	25	264		2,112	54
55	Electrical Work - Receptacles for Floor Removal	2011	3,225	215	15	215		1,666	55
56	Electrical Work - NH Renovations	2011	64,037	4,269	15	4,269		33,085	56
57	Flooring - NH Renovations	2011	178,640	17,864	10	17,864		138,446	57
58	Asbestos Monitoring - west wing, east wing, hallway	2011	11,352	757	15	757		5,866	58
59	Flooring - Plank 2 med room, 2 utility room, 2 clean linen room	2011	2,430	243	10	243		1,883	59
60	Flooring - Rubber Floor and Plank 4 shower rooms, 4 soiled rooms	2011	14,740	1,474	10	1,474		11,423	60
61	Flooring - Plank and Non-slip VCT physical therapy, dining room, and D	2011	13,654	1,365	10	1,365		10,579	61
62	Asbestos Removal - patient rooms hallways and common areas	2011	80,000	5,333	10	5,333		41,331	62
63	Sprinkler System Upgrade - NH	2011	19,454	1,297	15	1,297		10,376	63
64	Sign - care center entrance	2012	5,057	140	15	140		854	64
65	Capitalized Interest for CIP	2012	2,178	43	25	43		301	65
66	Stucco and painting nursing home building	2011	27,500	4,583	5	4,583		27,500	66
67	cabinets - kitchenette	2011	963	32	15	32		224	67
68	cabinets - kitchenette	2011	964	32	15	32		224	68
69	countertops - kitchenette	2011	767	25	15	25		175	69
70	TOTAL (lines 4 thru 69)		$ 1,582,139	$ 80,280		$ 80,280	$	$ 1,334,042	70

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

Facility Name & ID N Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/20 Ending: 06/30/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,582,139	$ 80,280		$ 80,280	$	$ ########	1
2	electrical upgrade - NH	2011	21,050	526	20	526		3,156	2
3	flooring - chapel, administration, storage ro	2011	12,618	630	10	630		3,780	3
4	front door, back door leading to hospital, de	2011	25,943	1,946	10	1,946		11,676	4
5	dining room, chapel and bathroom renovati	2011	90,720	3,024	15	3,024		18,144	5
6	bathroom renovation	2011	21,500	716	15	716		4,296	6
7	flooring - small dining room	2011	5,950	298	10	298		1,788	7
8	sink - kitchenette	2011	349	11	15	11		66	8
9	electrical upgrade - nh	2011	10,000	250	20	250		1,500	9
10	flooring - therapy room	2011	1,350	67	10	67		402	10
11	Ac - rooftop	2011	13,150	1,096	10	1,096		6,576	11
12	Nurse on call system	2011	70,687	3,534	10	3,534		21,204	12
13	television - dining room	2011	1,475	245	5	245		1,470	13
14	ac - 2 patient rooms	2011	2,950	98	15	98		588	14
15	hvac - all patient rooms and entire building	2011	114,219	3,807	15	3,807		22,842	15
16	landscaping - nursing home	2012	4,345	435	10	435		2,609	16
17	nurse call system additional rooms (102 & 4	2012	2,794	279	10	279		1,675	17
18	ac unit for laundry room	2013	8,250	550	15	550		3,300	18
19	wheelchair, rock & go	2013	1,564	104	15	104		625	19
20	television in chapel	2013	478	0	3	0		478	20
21	scale chair w/lift away arms & footrest 400l	2012	1,699	170	10	170		1,020	21
22	wheelchair, rock & go, color = port	2012	1,863	373	5	373		1,967	22
23	lift, sara 3000	2013	4,680	468	10	468		2,808	23
24	resident alarm system (6/30/14)	2014	23,500	2,350	10	2,350		9,400	24
25	wheelchair cushions	2014	3,090	172	3	172		860	25
26	chairs (vinyl)	2014	733	41	3	41		205	26
27	bed, bariatric with rails and foot control	2014	3,346	116	12	116		580	27
28	mattress, qty 42	2014	16,103	335	8	335		1,675	28
29	scale, wheelchair	2014	3,356	56	10	56		280	29
30	oxygen sensor, qty 4	2014	2,847	30	8	30		150	30
31	table, overbed, windsor mahogony, qty 44	2013	3,914	217	15	217		1,085	31
32	recliners	2013	3,935	183	15	183		833	32
33	mattress, qty 14	2013	5,281	495	8	495		2,475	33
34	TOTAL (lines 1 thru 33)		$ 2,065,878	$ 102,902		$ 102,902	$ 0	$ ########	34

0

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 1,131,388	$ 76,960	$ 76,960	$		$ 795,541	71
72	Current Year Purchases	30,357	2,926	2,926			2,926	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,161,745	$ 79,886	$ 79,886	$		$ 798,467	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)	$ 2,743,884	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,166	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,166	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,132,509	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 Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/1	2224	hrs	$ 82,351		$	$	2,224	$ 82,351	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a/1	847.3	hrs	35,154				847	35,154	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$ 117,504		$	$	3,071	$ 117,504	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.

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2018 (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	$ (64,707)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	338,981		3
4	Supply Inventory (priced at)	10,470		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,447		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 300,191	$	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 Cos	1,055,886		15
16	Equipment, at Historical Cost	998,398		16
17	Accumulated Depreciation (book methods)	(1,482,783)		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):	8,100		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 940,239	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,240,430	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,197	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,539		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,247		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	Other Accrued Liabilities	513,446		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 696,429	$	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)**	$ 696,429	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 544,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,240,430	$	48

*(See instructions.)

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 914,075	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 914,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(370,074)	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)**	$ (370,074)	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)**	$ 544,001	24 *

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

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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	$ 5,908,646	1
2	Discounts and Allowances for all Levels	(890,169)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,018,477	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	15,432	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	420	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)**	$ 15,852	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	Gain/Loss Disposal F/A	(860)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (860)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,033,468	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,403,542	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,403,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	(370,074)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (370,074)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,098,171	44
45	Private Pay - Net Inpatient Revenue	1,693,654	45
46	Medicare - Net Inpatient Revenue	996,106	46
47	Other-(specify) Managed Care	230,546	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,018,477	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,136	2,340	$ 92,416	$ 39.49	1
2	Assistant Director of Nursing	1,645	1,792	57,173	31.91	2
3	Registered Nurses	15,480	16,150	576,028	35.67	3
4	Licensed Practical Nurses	23,575	24,759	757,118	30.58	4
5	CNAs & Orderlies	61,070	64,284	1,024,968	15.94	5
6	CNA Trainees					6
7	Licensed Therapist	3,983	4,136	156,929	37.94	7
8	Rehab/Therapy Aides	2,732	2,807	68,857	24.53	8
9	Activity Director	1,840	1,989	31,783	15.98	9
10	Activity Assistants	1,059	1,220	14,825	12.15	10
11	Social Service Workers	4,062	4,552	78,100	17.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,518	1,534	27,309	17.81	17
18	Housekeepers	9,880	10,890	117,416	10.78	18
19	Laundry	3,567	4,089	47,889	11.71	19
20	Administrator	1,848	2,024	93,804	46.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,637	1,939	31,787	16.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	29	29	7,200	248.28	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,606	1,809	26,354	14.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,665	146,341	$ 3,209,956 *	$ 21.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,880	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	37	2,240	10/3	44
45	Social Service Consultant	37	2,240	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	74	$ 7,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	449	13,066	10/3	52
53	TOTAL (lines 50 - 52)	449	$ 13,066		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laura Northway	Admin	0	$ 93,804
Robin Vellett	Reception	0	31,787
Amy Rohlfing	Med Dir	0	7,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,791

B. Administrative - Other

Description	Amount
Beauty Shop Services	$ 14,201
Cost report prep fees	0
Postage, supplies, Benefit Admin fees, Record Storage, Phone	146,819
TOTAL (agree to Schedule V, line 17, col. 3)	$ 161,020
(Attach a copy of any management service agreement)	

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,676
Unemployment Compensation Insurance	28,546
FICA Taxes	233,122
Employee Health Insurance	268,980
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	15,603
Life Insurance	1,932
Other	1,135
TOTAL (agree to Schedule V, line 22, col.8)	$ 644,993

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,142
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 55)	2,765
Patient Background Checks 88	1,408
Illinois Health Care Association	7,403
Misc	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,767

G. Schedule of Travel and Seminar**

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

**See instructions.

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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. **Ill Health Care Association $7,403**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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?

(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 expens and the location of this expense on Sch. V. $ **50,697** Line

(7) Have all costs reported on this form been determined using accounting procedure 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.

(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 fo 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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **227,946**
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 classifiec in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services fo 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 benefit on Schedule V. $ **NA** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **420**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
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. $ NA

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

(18) Have all costs which do not relate to the provision of long term care been adjusted ou 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. **NA**
Attach invoices and a summary of services for all architect and appraisal fees