		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: 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 1/1/18 to 12/31/18 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: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,091	8,833	5,703	23,627	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,091	8,833	5,703	23,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.63%

D. How many bed reserve days during this year were paid by the Department?
none (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)
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 3,350

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	132,327	30,431	197,601	360,359		360,359	-	360,359			1
2	Food Purchase		112,368		112,368		112,368	-	112,368			2
3	Housekeeping	-	25,305	165,217	190,522		190,522	-	190,522			3
4	Laundry	-	10,250	110,199	120,449		120,449	-	120,449			4
5	Heat and Other Utilities			114,903	114,903		114,903	1,533	116,436			5
6	Maintenance	49,027	18,246	181,430	248,703		248,703	(6,301)	242,402			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	181,354	196,600	769,350	1,147,304		1,147,304	(4,768)	1,142,536			8
	B. Health Care and Programs											
9	Medical Director	-	-	18,000	18,000		18,000	-	18,000			9
10	Nursing and Medical Records	1,562,638	135,415	280,859	1,978,912		1,978,912	-	1,978,912			10
10a	Therapy	-	-	-				-				10a
11	Activities	72,937	4,479	1,853	79,269		79,269	-	79,269			11
12	Social Services	65,992	-	4,335	70,327		70,327	-	70,327			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	1,701,567	139,894	305,047	2,146,508		2,146,508		2,146,508			16
	C. General Administration											
17	Administrative	96,471	-	291,438	387,909		387,909	(291,438)	96,471			17
18	Directors Fees			-				-				18
19	Professional Services			213,996	213,996		213,996	2,179	216,175			19
20	Dues, Fees, Subscriptions & Promotions			45,920	45,920		45,920	(2,898)	43,022			20
21	Clerical & General Office Expenses	91,329	33,913	49,931	175,173		175,173	195,039	370,212			21
22	Employee Benefits & Payroll Taxes			530,576	530,576		530,576	-	530,576			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			4,807	4,807		4,807	-	4,807			24
25	Other Admin. Staff Transportation		-	59,310	59,310		59,310	39,626	98,936			25
26	Insurance-Prop.Liab.Malpractice			135,078	135,078		135,078	343	135,421			26
27	Other (specify):* HO Alloc - Benefits	-	-	-				24,785	24,785			27
28	**TOTAL General Administration**	187,800	33,913	1,331,056	1,552,769		1,552,769	(32,364)	1,520,405			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,070,721	370,407	2,405,453	4,846,581		4,846,581	(37,132)	4,809,449			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: 1/1/18 Ending: 12/31/18

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			65,038	65,038		65,038	37,775	102,813			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			100,375	100,375		100,375	(3,185)	97,190			32
33	Real Estate Taxes			57,000	57,000		57,000	-	57,000			33
34	Rent-Facility & Grounds			701,543	701,543		701,543	-	701,543			34
35	Rent-Equipment & Vehicles			56,470	56,470		56,470	2,505	58,975			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			980,426	980,426		980,426	37,095	1,017,521			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	245,104	503,982	749,086		749,086	(34,639)	714,447			39
40	Barber and Beauty Shops	-	-	416	416		416	-	416			40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			190,292	190,292		190,292	-	190,292			42
43	Other (specify):* Non-Allowable Cos	-	-	427,111	427,111		427,111	(427,111)				43
44	**TOTAL Special Cost Centers**		245,104	1,121,801	1,366,905		1,366,905	(461,750)	905,155			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,070,721	615,511	4,507,680	7,193,912		7,193,912	(461,787)	6,732,125			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: 1/1/18 Ending: 12/31/18

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	(9,245)	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	37,585	30		9
10	Interest and Other Investment Income	(6,775)	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	(51,037)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,919)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(345,000)	43		24
25	Fund Raising, Advertising and Promotional	(6,060)	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 PG5A	(33,480)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (422,931)		$	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)	(38,856)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (38,856)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (461,787)		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: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology	$ (6,521)	43	1
2	Laboratory	(9,248)	43	2
3	Capitalize Repairs Expense	(7,116)	6	3
4	Disallow Rotary Club & Chamber of Commerce Dues	(905)	20	4
5	Other Revenue offset	(7,103)	21	5
6	Lobbying	(2,587)	20	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**	(33,480)		49

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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
See Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 6-Supplemental		

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			$			$	$ *	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: 1/1/18 Ending: 12/31/18

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	100.00%	$ 1,533	$ 1,533	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	815	815	16
17	V	17	Management Fees	291,438	WW Healthcare Consultants, LLC	100.00%		(291,438)	17
18	V	19	Professional Services		WW Healthcare Consultants, LLC	100.00%	11,098	11,098	18
19	V	20	Dues, Fees, Subs. & Promotions		WW Healthcare Consultants, LLC	100.00%	394	394	19
20	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	24,964	24,964	20
21	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	9,765	9,765	21
22	V	21	Salaries/Wages		WW Healthcare Consultants, LLC	100.00%	167,613	167,613	22
23	V	24	Travel/Seminar		WW Healthcare Consultants, LLC	100.00%	11,326	11,326	23
24	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	343	343	24
25	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	24,785	24,785	25
26	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	190	190	26
27	V	32	Interest	99,161	WW Healthcare Consultants, LLC	100.00%	102,751	3,590	27
28	V	35	Rent		WW Healthcare Consultants, LLC	100.00%	2,505	2,505	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			$ 390,599			$ 358,082	$ * (32,517)	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: 1/1/18 Ending: 12/31/18

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 Benefits - Work. Comp	$ 82,548	SCK Assurance, LLC	0.00%	$ 82,548	$	15
16	V	22	Employee Benefits - Health Insurance	23,831	SCK Assurance, LLC	0.00%	23,831		16
17	V	26	Insurance - RAC Audit	15,544	SCK Assurance, LLC	0.00%	15,544		17
18	V	26	Insurance - Gen & Prof Liability	59,717	SCK Assurance, LLC	0.00%	59,717		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			$ 181,640			$ 181,640	$ *	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: 1/1/18 Ending: 12/31/18

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	$ 15,215	DMG Aero		$ 43,515	$ 28,300	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			$ 15,215			$ 43,515	$ * 28,300	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: 1/1/18 Ending: 12/31/18

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	39	Physical Therapy	$ 171,158	Adaptive NC, LLC		$ 166,400	$ (4,758)	15
16	V	39	Occupational Therapy	157,636	Adaptive NC, LLC		130,585	(27,051)	16
17	V	39	Speech Therapy	35,917	Adaptive NC, LLC		33,087	(2,830)	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			$ 364,711			$ 330,072	$ * (34,639)	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: 1/1/18 Ending: 12/31/18

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	Morris Sterling Holdings, LLC	100%	Regence Care of Mountain Ridge	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.	1
2			Regence Care of Mount Sterling	Kentucky	Walnut Grove Cottage	Morris, IL	Independent Liv.	2
3			Regence Care of Blountstown	Florida	N100LW, LLC	Hickory, NC	Airplane entity	3
4			Regence Care of Sterling	Sterling, IL	DMG Aero , LLC	Hickory, NC	Airplane entity	4
5			Regence Care of Arlington, LLC	Virginia	Regency Holdings LLC	Hickory, NC	Holding Co.	5
6			Regence Care of Silver Spring LLC	Silver Spring, MD	SCK Assurance LLC	Hickory, NC	Insurance Co.	6
7			Saphire Health Care LLC	Copley, OH	WW Healthcare Consu	Hickory, NC	Mgmt Co.	7
8			(DBA Regency Care of Copley)		Regency Memory Care	Mount Sterling, KY	Assisted Living	8
9					AdaptNC, LLC	North Carolina	Therapy	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 REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 compensation from this facility.								$		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: 1/1/18 Ending: 12/31/18

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	296,951	9	$ 19,263	$	23,627	$ 1,533	1
2	6	Maintenance & Repair - Other	Resident days	296,951	9	10,245		23,627	815	2
3	19	Professional Services	Resident days	296,951	9	139,479		23,627	11,098	3
4	20	Dues, Fees, Subs. & Promotions	Resident days	296,951	9	4,955		23,627	394	4
5	21	Clerical/General-Other	Resident days	296,951	9	313,757		23,627	24,964	5
6	21	Office/Other Supplies	Resident days	296,951	9	122,724		23,627	9,765	6
7	21	Salaries/Wages	Resident days	296,951	9	2,106,612	2,106,612	23,627	167,613	7
8	24	Travel/Seminar	Resident days	296,951	9	142,345		23,627	11,326	8
9	26	Insurance	Resident days	296,951	9	4,311		23,627	343	9
10	27	Employee Benefits	Resident days	296,951	9	311,500		23,627	24,785	10
11	30	Depreciation	Resident days	296,951	9	2,388		23,627	190	11
12	32	Interest	Resident days	296,951	9	45,114		23,627	102,751	12
13	35	Rent	Resident days	296,951	9	31,481		23,627	2,505	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					$ 3,254,174	$ 2,106,612		$ 358,082	25

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Benefits-Work Comp	Direct Cost			$	$		$ 82,548	1
2	22	Employee Benefits - Health Insura	Direct Cost						23,831	2
3	26	Insurance - RAC Audit	Direct Cost						15,544	3
4	26	Insurance - Gen & Prof Liability	Direct Cost						59,717	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					$	$		$ 181,640	25

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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: 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			$	$		$ 43,515	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					$	$		$ 43,515	25

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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: AdaptNC, 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	39	Physical Therapy	Direct Cost			$	$		$ 166,400	1
2	39	Occupational Therapy	Direct Cost						130,585	2
3	39	Speech Therapy	Direct Cost						33,087	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					$	$		$ 330,072	25

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	N/A						$	$			$	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								WW Healthcare Int Exp Adj			3,590	10
11								Finance Charges			1,214	11
12								Interest Income Offset			(6,775)	12
13								Allocated from Home Office			99,161	13
14	TOTAL Non-Facility Related						$	$			$ 97,190	14
15	TOTALS (line 9+line14)						$	$			$ 97,190	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: 1/1/18 Ending: 12/31/18

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.**		$ 55,524	1
	2017		
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.)		$ 55,524	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,000	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.		$ 57,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	85,457	8
	2014	83,359	9
	2015	88,635	10
	2016	85,916	11
	2017	55,524	12

Accrual Calculation: FY17 RE Tax Expense $55,524 * 1.02 = $56,634. use $57,000

	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 Morris SNF Management, LLC 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 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.	02-33-303-020	Nursing Facility	$ 55,524.40	$ 55,524.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,524.40	$ 55,524.40

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 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 REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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).

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: 1/1/18 Ending: 12/31/18

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		6,384	11
12	Carpet			2009	3,183	-	5	-		3,183	12
13						-		-			13
14	New Wing Construction			2010	20,853	2,085	10	2,085		17,725	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		8,797	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		2,680	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		13,300	27
28	hallways, bathrooms & nursing station, pressure test					-		-			28
29						-		-			29
30	Hot Water Replacement			2010	4,800	-	10	480	480	4,080	30
31						-		-			31
32	HVAC and Sprinkler System throughout facility			2010	77,975	-	10	7,798	7,798	66,283	32
33	New Cooling Tower			2010	27,775	-	10	2,778	2,778	23,613	33
34	Renovate hallway and replace nursing station with private			2010	44,307	-	10	4,431	4,431	37,664	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: 1/1/18 Ending: 12/31/18

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	$ 3,501	37
38	RF Technologies-Wanderer System	2011	9,531	-	5	-		9,531	38
39	Illinois Electric Services Inv 113009336,113011336,113014336 Elec	2011	9,350	935	10	935		7,013	39
40	Illinois Electric Services - Install code alert model	2011	7,300	-	7	522	522	7,300	40
41	Menards - BTU Window AC & Stand fan	2011	3,119	-	10	312	312	2,339	41
42	Menards - BTU Window AC & ELEC DEHUM SOL	2011	3,638	-	10	364	364	2,729	42
43				-		-			43
44	Sprinkler System - Nursing Home	2012	10,326	1,033	10	1,033	0	6,712	44
45	New Door Installation - Employee Entrance & Service Hall	2012	6,330	633	10	633	(0)	4,115	45
46	R/M Reclass: Chiller Condenser (outside, service entrance)	2012	2,762	-	5			2,762	46
47	Equipment Reclass: Generator (outside, off large dining rm.)	2012	4,617	-	5			4,617	47
48				-		-			48
49	Heat Pump Installation in Hallway One	2013	7,513	412	10	751	339	4,131	49
50	New Door Installation - Nursing Home	2013	13,137	1,314	10	1,314	0	7,227	50
51	New Fire Sprinkler Installation in Boiler Room	2013	5,750	575	10	575		3,163	51
52	R/M Reclass: Heat Pump & Blower-Hallway 1 (Dining RM & Kitc	2013	2,695	-	10	270	270	1,485	52
53	R/M Reclass: Garcia Masonry	2013	3,800	-	10	380	380	2,090	53
54				-		-			54
55	R/M Reclass: Guttering, corners, fascia & downspouts for bldg	2014	2,870	-	10	287	287	1,292	55
56	R/M Reclass: Building HVAC unit controls	2014	2,640	-	5	528	528	2,376	56
57	R/M Reclass: EMCOR-Replace Fan (HP#5); replace compressor	2014	5,230	-	5	1,046	1,046	4,707	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	3,695	59
60	motor on the hall unit			-		-			60
61	R/M Reclass: Generator repair- Rear of building	2014	2,547	-	5	509	509	2,293	61
62	R/M Reclass: Repair of boiler & heat pump in kitchen, admin	2014	4,098	-	5	820	820	3,688	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	8,123	65
66	RF Technologies - Wanderer system	2014	17,335	-	5	3,467	3,467	15,602	66
67	D Construction inv 22294 - Driveway extension	2014	21,075	2,634	8	2,634	(0)	11,855	67
68	R/M Reclass: EMCOR-Replace compressor-Mech rm.-Inspect	2014	5,220	-	5	1,044	1,044	4,698	68
69	& evaluate 45 heat pumps-Replace/Repair where necessary			-		-			69
70	TOTAL (lines 4 thru 69)		$ 404,678	$ 13,208		$ 41,676	$ 28,468	$ 320,622	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: 1/1/18 Ending: 12/31/18

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		$ 41,676	$ 28,468	$ 320,622	1
2				-		-			2
3	Replacement of failed coil for the fluid cooler in the cooling tower	2015	53,850	-	10	5,385	5,385	18,848	3
4	R/M Reclass: EMCOR-Inspect & evaluate 11 heat pumps.	2015	3,633	-	5	727	727	2,543	4
5	Replace/Repair where necessary. Mechanical Room.			-		-			5
6				-		-			6
7	Walk-In Cooler. Kitchen	2016	7,366	491	15	491	(0)	1,228	7
8	Hot Water Heater. Mechanical Room	2016	8,086	809	10	809		2,021	8
9	5 Comfort Aire Heat Pumps	2016	24,785	2,479	10	2,479		6,196	9
10	Goldy Lock Door Replacement	2016	12,271	818	15	818	(0)	2,045	10
11	Air Cooled Chillder for HVAC. Mechanical Room	2016	51,800	3,453	15	3,453		8,634	11
12	Coil System. Mechical Room	2016	53,850	3,590	15	3,590		8,975	12
13	Flow Meters for Heat Pumps	2016	22,262	2,226	10	2,226	0	5,565	13
14	Turn Around in Front Building	2016	5,000	500	10	500		1,250	14
15	R&M Reclass: Replace pipe in fire system. Throughout Building	2016	17,924	-	25	717	717	1,792	15
16				-		-			16
17	2 Comfort Aire Heat Pumps	2017	10,119	1,012	10	2,481	1,469	2,987	17
18	Comfort Aire Heat Pump	2017	5,237	524	10	1,201	677	1,463	18
19				-		-			19
20	Chiller Compressor - Outside next to Patio	2018	5,353	114	15	114		114	20
21	New Signage - Outside & Throughout Building	2018	6,695	38	10	38		38	21
22	R&M Reclass: Replace pipe for laundry boilers and storage	2018	7,116	-	25	142	142	142	22
23	tank.			-					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)		$ 700,025	$ 29,261		$ 66,846	$ 37,585	$ 384,462	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: 1/1/18 Ending: 12/31/18

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	$ 218,804	$ 25,715	$ 25,715	$ -	5-20 years	$ 152,368	71
72	Current Year Purchases	23,686	1,243	1,243	-	5-10 years	1,243	72
73	Fully Depreciated Assets	77,008			-		77,008	73
74	Home Office Allocation			190	190			74
75	TOTALS	$ 319,498	$ 26,958	$ 27,148	$ 190		$ 230,619	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	$ 5,513	76
77	Facility Use	02 Dodge Van	2015	5,183	1,296	1,296	-	4	4,536	77
78	Facility Use	2009 E-350 Van	2017	14,985	3,746	3,746	-	4	5,619	78
79	Facility Use	2010 E-350 Van	2018	25,800	2,202	2,202	-	4	2,202	79
80	TOTALS			$ 52,268	$ 8,819	$ 8,819	$		$ 17,870	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)	$ 1,071,791	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,038	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 102,813	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 37,775	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 632,951	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	CIP	$ 242,143	92
93			93
94			94
95		$ 242,143	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: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WC-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	$ 701,543			3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 701,543 **			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.	/2019	$ 721,747
13.	/2020	$ 742,534
14.	/2021	$ 763,919

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: $ 58,975 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: **12/31/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

	Rental Description	Amount
730620	Equipment Rental-Admin	499
911620	Equipment Rental-Nurse	38,957
912620	Equipment Rental-Dietary	1,427
930190	Other Rent/Lease Expense	15,587
9993	Home Office Allocation	2,505
	Total - Line 16	**58,975**

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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: 1/1/18 Ending: 12/31/18

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)(7)	hrs	$	3,933	$ 180,902	$	3,933	$ 180,902	1
2	Licensed Speech and Language Development Therapist	39(3)(7)	hrs		935	48,504		935	48,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)(7)	hrs		4,272	239,937	11,326	4,272	251,263	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				217,703		217,703	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39(3)					10,131		10,131	12
13	Other (specify): Oxygen	39(2)					5,944		5,944	13
14	TOTAL			$	9,140	$ 469,343	$ 245,104	9,140	$ 714,447	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: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 87,479	$ 87,479	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 467,832)	2,496,837	2,496,837	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	27,974	27,974	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Oth Curr Assets - See Sch 17A	635,362	635,362	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,247,652	$ 3,247,652	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	300,492	700,025	15
16	Equipment, at Historical Cost	427,358	371,766	16
17	Accumulated Depreciation (book methods)	(390,258)	(632,951)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	242,143	242,143	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 579,735	$ 680,983	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,827,387	$ 3,928,635	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,813,527	$ 3,813,527	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,073	7,073	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,432	163,432	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,000	57,000	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	141,350	141,350	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,182,382	$ 4,182,382	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)**	$ 4,182,382	$ 4,182,382	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (354,995)	$ (253,747)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,827,387	$ 3,928,635	48

***(See instructions.)**

Facility Name: **REGENCY CARE OF MORRIS**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/18**

Schedule 17A

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

	Description	Operating	After Consolidation
153000	Real Estate Tax Escrow	436,775	436,775
153500	Capital Improvements Escrow	34,234	34,234
161000	Resident Trust Cash	7,073	7,073
261000	Deposits-Utilities	8,579	8,579
262000	Deposits-Leases	65,080	65,080
263000	Deposits-Other	2,214	2,214
313100	W/H-Group Insurance	56,370	56,370
319800	W/H-Employee Advances	400	400
319875	Due To/From SCK	9,222	9,222
319880	Due To/From UMR	13,534	13,534
319890	Due to / from Symetra	1,881	1,881
	Total - Line 9	**635,362**	**635,362**

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

	Description	Operating	After Consolidation
37000	Suspense	16,446	16,446
132995	Due To Medicaid (Credit Bal)	33,370	33,370
313103	Health Savings Account	157	157
313600	Employee Retirement/Savings	67	67
319850	Due To/From Employee-Health In	7,347	7,347
332010	Escrows Payable to Wakefield	77,119	77,119
337000	Reserve for Mcaid/Mcare Audit	12,501	12,501
337100	Retro Revenue Reserve	(5,657)	(5,657)
	Total - Line 36	**141,350**	**141,350**

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,913,529	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(903,374)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,010,155	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,365,150)	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)**	$ (1,365,150)	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)**	$ (354,995)	24 *

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

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,400,961	1
2	Discounts and Allowances for all Levels	(2,479,791)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,921,170	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,264,883	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,264,883	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	448,110	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,312	19
20	Radiology and X-Ray	11,787	20
21	Other Medical Services	163,622	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 628,831	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,775	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,775	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Revenue	7,103	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,103	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,828,762	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,147,304	31
32	Health Care	2,146,508	32
33	General Administration	1,552,769	33
	B. Capital Expense		
34	Ownership	980,426	34
	C. Ancillary Expense		
35	Special Cost Centers	1,176,613	35
36	Provider Participation Fee	190,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,193,912	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,365,150)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,365,150)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,362,704	44
45	Private Pay - Net Inpatient Revenue	1,614,549	45
46	Medicare - Net Inpatient Revenue	(1,148,698)	46
47	Other-(specify) Managed Care	(269,087)	47
48	Other-(specify) See SCH 19A	361,702	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,921,170	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

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

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

^ Entity is a cash basis taxpayer

Facility Name: **REGENCY CARE OF MORRIS**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/18**

Schedule 19A

XVII. Income Statement
Line 48 Other Payers (specifu)

Description	Amount
Hospice	365,255
Other	(3,553)
Total - Line 28	**361,702**

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,304	1,458	$ 60,954	$ 41.81	1
2	Assistant Director of Nursing	1,312	1,355	40,961	30.23	2
3	Registered Nurses	14,079	14,803	465,624	31.45	3
4	Licensed Practical Nurses	11,008	11,763	301,568	25.64	4
5	CNAs & Orderlies	37,649	43,446	613,900	14.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,424	5,703	72,937	12.79	10
11	Social Service Workers	3,507	3,803	65,992	17.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,668	10,558	132,327	12.53	15
16	Dishwashers					16
17	Maintenance Workers	2,677	2,847	49,027	17.22	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,707	1,841	96,471	52.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,362	5,861	91,329	15.58	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	578	624	8,374	13.42	31
32	Other Health C: See Sch 20A	3,115	3,273	71,257	21.77	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,390	107,335	$ 2,070,721 *	$ 19.29	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	249	12,360	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Flat Rate	485	10(3)	37
38	Nurse Consultant	Monthly	1,713	10(3)	38
39	Pharmacist Consultant	Flat Rate	9,341	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	33	1,923	11(3)	44
45	Social Service Consultant	69	4,335	12(3)	45
46	Other(specify) Interim DON	Monthly	25,450	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	351	$ 73,607		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	338	$ 16,244	10(3)	50
51	Licensed Practical Nurses	123	5,147	10(3)	51
52	Certified Nurse Assistants/Aides	6,577	171,005	10(3)	52
53	TOTAL (lines 50 - 52)	7,038	$ 192,396		53

Facility Name: **REGENCY CARE OF MORRIS**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/18**

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
MDS Coordi	1,078	1,154	42,631	$ 36.94
Transportatic	2,037	2,119	28,626	$ 13.51
Total - Line	**3,115**	**3,273**	**71,257**	

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ma Maivette Gleeson	Administrator	0	$ 24,461
Christopher Rayborn	Administrator	0	23,402
Andrew Beyers	Administrator	0	48,608
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,471

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Column 7	$ 291,438
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 291,438

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C	See Sch 21C	$ 213,996
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 213,996

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,428
Unemployment Compensation Insurance	67,542
FICA Taxes	158,410
Employee Health Insurance	56,265
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	124,931
TOTAL (agree to Schedule V, line 22, col.8)	$ 530,576

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	26,141
Health Care Worker Background Check	2,193
(Indicate # of checks performed 219)	
Patient Background Checks 20	200
Miscellaneous Licenses & Fees	3,398
Miscellaneous Dues/Subscriptions	5,165
Management company allocation	394
IHCA	8,118
Noallowable Dues	(2,587)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,022

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,752
Seminar Expense	2,055
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,807

**See instructions.

Facility Name: **REGENCY CARE OF MORRIS**
IDPH License ID Number: **0050468**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	7,500
O'Hagan Spencer, LLC	Legal	173,832
Polsinelli Shughart	Legal	15,145
Income Tax Accrual	Accounting	3,000
Ogletree, Deakins, Nask, Smoak	Legal	982
Paylocity	Payroll Processing	13,537
Total (agree to Schedule V, line 19, column 3)		213,996
Allocated from Management Company	Professional Services	11,098
Less: Non-Allowable Legal Fees		(8,919)
Total (agree to Schedule V, line 19, column 8)		216,175

Facility Name & ID Number REGENCY CARE OF MORRIS # 0050468 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 $8,118**

(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? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,214** 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. $ **190,292**
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. $ **0** 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 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.