		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0050476

Facility Name: REGENCY CARE OF STERLING

Address: 612 West St. Mary's Street (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

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

HFS ID Number:

Date of Initial License for Current Owners: 08/01/2009

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 STERLING # 0050476 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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	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	9,204	10,913	7,517	27,634	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,204	10,913	7,517	27,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.24%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
None

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 130 and days of care provided 5,213

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 STERLING # 0050476 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	170,437	29,767	9,431	209,635		209,635	-	209,635			1
2	Food Purchase		211,341		211,341		211,341	(1,515)	209,826			2
3	Housekeeping	98,921	21,619	-	120,540		120,540	-	120,540			3
4	Laundry	40,623	5,744	-	46,367		46,367	-	46,367			4
5	Heat and Other Utilities			141,958	141,958		141,958	1,793	143,751			5
6	Maintenance	76,487	17,527	77,227	171,241		171,241	953	172,194			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	386,468	285,998	228,616	901,082		901,082	1,231	902,313			8
	B. Health Care and Programs											
9	Medical Director	-	-	18,000	18,000		18,000	-	18,000			9
10	Nursing and Medical Records	1,739,949	140,690	69,744	1,950,383		1,950,383	-	1,950,383			10
10a	Therapy	46,156	-	-	46,156		46,156	-	46,156			10a
11	Activities	71,635	2,554	4,330	78,519		78,519	-	78,519			11
12	Social Services	67,428	-	-	67,428		67,428	-	67,428			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	1,925,168	143,244	92,074	2,160,486		2,160,486		2,160,486			16
	C. General Administration											
17	Administrative	86,826	-	343,134	429,960		429,960	(338,534)	91,426			17
18	Directors Fees			-				-				18
19	Professional Services			80,143	80,143		80,143	9,150	89,293			19
20	Dues, Fees, Subscriptions & Promotions			20,837	20,837		20,837	(2,307)	18,530			20
21	Clerical & General Office Expenses	67,307	27,545	14,451	109,303		109,303	229,541	338,844			21
22	Employee Benefits & Payroll Taxes			773,032	773,032		773,032	-	773,032			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			4,409	4,409		4,409	-	4,409			24
25	Other Admin. Staff Transportation		-	26,974	26,974		26,974	19,570	46,544			25
26	Insurance-Prop.Liab.Malpractice			135,414	135,414		135,414	401	135,815			26
27	Other (specify):* HO Alloc Benefits	-	-	-				28,988	28,988			27
28	**TOTAL General Administration**	154,133	27,545	1,398,394	1,580,072		1,580,072	(53,191)	1,526,881			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,465,769	456,787	1,719,084	4,641,640		4,641,640	(51,960)	4,589,680			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 STERLING #0050476 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			56,581	56,581		56,581	34,039	90,620			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			19,188	19,188		19,188	(19,188)				32
33	Real Estate Taxes			110,692	110,692		110,692	-	110,692			33
34	Rent-Facility & Grounds			689,735	689,735		689,735	-	689,735			34
35	Rent-Equipment & Vehicles			37,262	37,262		37,262	2,930	40,192			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			913,458	913,458		913,458	17,781	931,239			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	230,805	645,132	875,937		875,937	(38,069)	837,868			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			204,548	204,548		204,548	-	204,548			42
43	Other (specify):* Non-Allowable Cos	-	-	296,166	296,166		296,166	(296,166)				43
44	**TOTAL Special Cost Centers**		230,805	1,145,846	1,376,651		1,376,651	(334,235)	1,042,416			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,465,769	687,592	3,778,388	6,931,749		6,931,749	(368,414)	6,563,335			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 STERLING # 0050476 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	(1,515)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,367)	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	33,817	30		9
10	Interest and Other Investment Income	(6,593)	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	(8,700)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,830)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(232,500)	43		24
25	Fund Raising, Advertising and Promotional	(20,111)	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	(36,373)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (284,172)		$	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)	(84,242)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (84,242)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (368,414)		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 STERLING

ID# 0050476

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology-Other Contracted Services	$ (7,308)	43	1
2	Lab-Contract Services	(19,180)	43	2
3	Offset Other Income Against A&G - Other	(7,117)	21	3
4	Non Allowable dues	(2,768)	20	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**	(36,373)		49

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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 STERLING # 0050476 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%	$ 1,793	$ 1,793	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	953	953	16
17	V	17	Management Fees	338,534	WW Healthcare Consultants, LLC	100.00%		(338,534)	17
18	V	19	Professional Services		WW Healthcare Consultants, LLC	100.00%	12,980	12,980	18
19	V	20	Licenses		WW Healthcare Consultants, LLC	100.00%	461	461	19
20	V	21	Salaries / Wages		WW Healthcare Consultants, LLC	100.00%	196,039	196,039	20
21	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	29,198	29,198	21
22	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	11,421	11,421	22
23	V	24	Travel & Seminars		WW Healthcare Consultants, LLC	100.00%	13,246	13,246	23
24	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	401	401	24
25	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	28,988	28,988	25
26	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	222	222	26
27	V	32	Interest	16,793	WW Healthcare Consultants, LLC	100.00%	4,198	(12,595)	27
28	V	35	Equipment Rent		WW Healthcare Consultants, LLC	100.00%	2,930	2,930	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			$ 355,327			$ 302,830	$ * (52,497)	39

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	$ 92,229	SCK Assurance LLC		$ 92,229	$	15
16	V	22	Employee Benefits - Health Insurance	54,173	SCK Assurance LLC		54,173		16
17	V	26	Insurance - RAC Audit	16,042	SCK Assurance LLC		16,042		17
18	V	26	Insurance - Gen & Prof Liability	61,223	SCK Assurance LLC		61,223		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			$ 223,667			$ 223,667	$ *	39

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	$ 3,400	DMG Aero		$ 9,724	$ 6,324	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			$ 3,400			$ 9,724	$ * 6,324	39

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	$ 201,689	Adaptive NC, LLC		$ 196,082	$ (5,607)	15
16	V	39	Occupational Therapy	179,288	Adaptive NC, LLC		148,522	(30,766)	16
17	V	39	Speech Therapy	21,529	Adaptive NC, LLC		19,833	(1,696)	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			$ 402,506			$ 364,437	$ * (38,069)	39

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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%	Regency Care of Mountain Ridge	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.	1
2			Regency Care of Mount Sterling	Kentucky	Walnut Grove Cottage	Morris, IL	Independent Liv.	2
3			Regency Care of Blountstown	Florida	N100LW, LLC	Hickory, NC	Airplane entity	3
4			Regency Care of Morris	Morris, IL	DMG Aero , LLC	Hickory, NC	Airplane entity	4
5			Regency Care of Arlington, LLC	Virginia	Regency Holdings LLC	Hickory, NC	Holding Co.	5
6			Regency Care of Silver Spring LLC	Silver Spring, MD	SCK Assurance LLC	Hickory, NC	Insurance Co.	6
7			Sapphire 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								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 STERLING # 0050476 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									$		1
2											2
3											3
4											4
5											5
6											6
7		Note : No owners received compensation from this facility.									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 STERLING # 0050476 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	Patient Days	296,951	9	$ 19,263	$	27,634	$ 1,793	1
2	6	Maintenance & Repair - Other	Patient Days	296,951	9	10,245		27,634	953	2
3	19	Professional Services	Patient Days	296,951	9	139,479		27,634	12,980	3
4	20	Licenses	Patient Days	296,951	9	4,955		27,634	461	4
5	21	Salaries / Wages	Patient Days	296,951	9	2,106,612	2,106,612	27,634	196,039	5
6	21	Clerical/General-Other	Patient Days	296,951	9	313,757		27,634	29,198	6
7	21	Office/Other Supplies	Patient Days	296,951	9	122,724		27,634	11,421	7
8	24	Travel	Patient Days	296,951	9	142,345		27,634	13,246	8
9	26	Insurance	Patient Days	296,951	9	4,311		27,634	401	9
10	27	Employee Benefits	Patient Days	296,951	9	311,500		27,634	28,988	10
11	30	Depreciation	Patient Days	296,951	9	2,388		27,634	222	11
12	32	Interest	Patient Days	296,951	9	45,114		27,634	4,198	12
13	35	Equipment Rent	Patient Days	296,951	9	31,481		27,634	2,930	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		$ 302,830	25

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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			$	$		$ 92,229	1
2	22	Employee Benefits - Health Insura	Direct Cost						54,173	2
3	26	Insurance-RAC Audit	Direct Cost						16,042	3
4	26	Insurance-Gen & Prof Liability	Direct Cost						61,223	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					$	$		$ 223,667	25

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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 NE
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			$	$		$ 9,724	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					$	$		$ 9,724	25

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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 ☐ NO ☐

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

Name of Related Organization: Adaptive NC, 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			$	$		$ 196,082	1
2	39	Occupational Therapy	Direct Cost						148,522	2
3	39	Speech Therapy	Direct Cost						19,833	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					$	$		$ 364,437	25

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note Original	7 Amount of Note Balance	8 Maturity Date	9 Interest Rate (4 Digits)	10 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								Finance Charges			2,395	10
11								Offset Interest Income			(6,593)	11
12								Allocated from Home Office			(12,595)	12
13								WW Healthcare Int Exp Adj			16,793	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. $ 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 STERLING # 0050476 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.**		$	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.)	2017	$ 275,549	2
3. Under or (over) accrual (line 2 minus line 1).		$ 275,549	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.)**	Cottage taxes - Non-Allowable (164,857)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 110,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	258,255	8
2014	263,554	9
2015	278,221	10
2016	277,467	11
2017	275,549	12

Facility does not accrue real estate taxes.

	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 Sterling SNF Management, LLC COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0050476

CONTACT PERSON REGARDING THIS REPORT Gene Woodward

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.	11-16-151-003	Long-Term Care Property	$ 275,252.42	$ 110,395.28
2.	11-16-151-002	Long-Term Care Property	$ 296.72	$ 296.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 275,549.14	$ 110,692.00

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? X 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 REGENCY CARE OF STERLING # 0050476 Report Period Beginning: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,700 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).

68 Cottages - Cost not included on cost report

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	Plumbing			2009	5,076	338	15	339	1	3,136	9
10	Plumbing			2010	7,897	790	10	790	(0)	6,779	10
11	Mixing Valves			2009	3,305	-	15	220	220	2,017	11
12	Heater Repair			2010	3,450	-	5	-		3,450	12
13	Generator Repair			2010	4,331	-	5	-		4,331	13
14	Generator Repair			2010	2,981	-	5	-		2,981	14
15	TD Kurtz glass new door			2011	9,397	470	20	470	0	3,525	15
16	TD Kurtz glass new door			2011	9,297	465	20	464	(1)	3,480	16
17	Repairs-Carpet Service			2011	2,729	-	20	136	136	1,020	17
18	Repairs-Site inspection			2011	8,446	-	20	422	422	3,165	18
19	Repairs-Roofing power			2011	2,910	-	20	146	146	1,095	19
20						-		-			20
21	New Heat Exchanger			2013	8,700	870	10	870		4,785	21
22	Replace Existing Water Soure Heat Pumps			2013	48,785	4,879	10	4,879	1	26,834	22
23	HVAC			2013	2,500	-	10	250	250	1,375	23
24	Interior Design Fee			2013	4,400		10	440	440	2,420	24
25						-		-			25
26	New Phones and Phone System-Entire Facility			2014	17,468	1,747	10	1,747	0	7,861	26
27	New Roof			2014	174,900	17,490	10	17,490		78,705	27
28	New AO Smith 100 Gallon Hot Water Heater			2014	3,996		10	400	400	1,800	28
29	Install new outside condensing unit			2014	3,800		10	380	380	1,710	29
30	Repair for 2 Generators			2014	2,533		10	253	253	1,139	30
31											31
32	Remove Condensor from 400 wing and install new			2015	2,595		10	260	260	909	32
33											33
34	B&A Glass Retaining Wall outside of 300 hall on southeast			2016	6,250	313	20	313		782	34
35	section of building										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 STERLING # 0050476 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			$	$		$	$	$	37
38				-		-			38
39	Remove Water Based Heat Pumps & Install Forced Air Units	2010	250,805		10	25,081	25,081	213,189	39
40	and Additional Duct Work for Air Flow-Half of Facility			-		-			40
41	Renovate Hallway and Replace Nurse Station with Private	2010	53,123	-	10	5,312	5,312	45,153	41
42	Rooms - Villa Hall			-		-			42
43						-			43
44	Phone and Parking Lot Light Repairs	2016	10,000	1,000	10	1,000		2,500	44
45	New water heater in mechanical room	2018	7,669	569	10	569		569	45
46	Paving parking lot and fixing holes	2018	19,880	1,209	8	1,209		1,209	46
47				-		-			47
48				-		-			48
49				-		-			49
50	Reconcile to book depreciation			(516)		-	516		50
51				-		-			51
52				-		-			52
53				-		-			53
54				-		-			54
55				-		-			55
56				-		-			56
57				-		-			57
58				-		-			58
59				-		-			59
60				-		-			60
61				-		-			61
62				-		-			62
63				-		-			63
64				-		-			64
65				-		-			65
66				-		-			66
67				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 677,223	$ 29,623		$ 63,440	$ 33,817	$ 425,919	70

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	$ 117,963	$ 17,653	$ 17,653	$ -	5	$ 90,860	71
72	Current Year Purchases	10,322	975	975	-	5	975	72
73	Fully Depreciated Assets	50,328			-	5	50,328	73
74	Management Company Allocation			222	222	5		74
75	TOTALS	$ 178,613	$ 18,628	$ 18,850	$ 222		$ 142,163	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	Chevy Snow Truck 1999	2015	$ 4,800	$ 960	$ 960	$ -	5	$ 3,360	76
77	Facility Use	Chevy Van 2002	2015	8,449	1,690	1,690	-	5	5,915	77
78	Facility Use	E-350 Van 2009	2016	24,000	4,800	4,800	-	5	12,000	78
79	Facility Use	2000 GMC Sierra K2500	2018	4,800	880	880	-	5	880	79
80	TOTALS			$ 42,049	$ 8,330	$ 8,330	$		$ 22,155	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)	$ 897,885	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,581	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,620	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,039	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 590,237	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		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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: Wakefield Communities-Sterling

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:		130	08/2009	$ 689,735			3
4	Additions							4
5								5
6								6
7	TOTAL		130		$ 689,735 **			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: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2010
Ending 03/31/2025

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$ 709,599
13.	/2020	$ 730,035
14.	/2021	$ 751,060

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

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

16. Rental Amount for movable equipment: $ 40,192 Description: Dish Machine $1,125; Nurse Equipment $36,137; HO Allocation $2,930
(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 & ID Number REGENCY CARE OF STERLING # 0050476 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 STERLING # 0050476 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	$	5,301	$ 263,475	$	5,301	$ 263,475	1
2	Licensed Speech and Language Development Therapist	39(3),(7)	hrs		1,184	33,565		1,184	33,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3),(7)	hrs		5,964	310,023	397	5,964	310,420	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				229,440		229,440	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory	39(2)					968		968	13
14	TOTAL			$	12,449	$ 607,063	$ 230,805	12,449	$ 837,868	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 STERLING # 0050476 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	$ 6,962	$ 6,962	1
2	Cash-Patient Deposits	33,496	33,496	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 363,137)	1,074,779	1,074,779	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,916	4,916	6
7	Other Prepaid Expenses	17,322	17,322	7
8	Accounts Receivable (owners or related parties)	349,704	349,704	8
9	Other(specify): See Schedule 17A	281,992	281,992	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,769,171	$ 1,769,171	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	355,091	677,223	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	220,662	220,662	16
17	Accumulated Depreciation (book methods)	(323,732)	(590,237)	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): See Schedule 17A	236,628	236,628	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 488,649	$ 544,276	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,257,820	$ 2,313,447	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,517,293	$ 1,517,293	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,496	33,496	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,880	141,880	30
31	Accrued Taxes Payable (excluding real estate taxes)			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	See Schedule 17A	66,058	66,058	36
37	See Schedule 17A	2,578,123	2,578,123	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,336,850	$ 4,336,850	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)**	$ 4,336,850	$ 4,336,850	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,079,030)	$ (2,023,403)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,257,820	$ 2,313,447	48

***(See instructions.)**

Facility Name: REGENCY CARE OF STERLING
IDPH License ID Number: 0050476
Fiscal Year End: 12/31/18

Schedule 17A

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

Description	Operating	After Consolidation
Real Estate Tax Escrow	266,681	266,681
W/H Group Insurance	7,846	7,846
Due To/From Employee Heath Insurance	1,358	1,358
Due to/From Sick	5,607	5,607
Due to/from Symetra	500	500
Total - Line 9	**281,992**	**281,992**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Capital Improvements Escrow	169,234	169,234
Deposits-Utilities	4,625	4,625
Deposits-Leases	62,756	62,756
Deposits-Other	13	13
Total - Line 23	**236,628**	**236,628**

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

Description	Operating	After Consolidation
Suspense	12,139	12,139
Accrued PTO	70,453	70,453
Health Savings Account	291	291
RC Benefits Liability Fund	(124,061)	(124,061)
Real Estate Taxes	110,692	110,692
General/Property/Liability Insurance	10,752	10,752
Retro Revenue Reserve	(14,208)	(14,208)
Total - Line 36	**66,058**	**66,058**

XV. Balance Sheet
Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due To/From Medicare Bad Debt	(72,422)	(72,422)
Due To Medicaid (credit Bal)	138,609	138,609
Due To/From WWHCC	2,519,701	2,519,701
Due To/From UMR	(16,826)	(16,826)
Reserve for MCAID/MCARE Audit	9,061	9,061
Total - Line 37	**2,578,123**	**2,578,123**

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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**	$ 306,859	1
2	Restatements (describe):		2
3	**Changes in Equity**	(2,224,817)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,917,958)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(161,072)	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)**	$ (161,072)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,079,030)	24 *

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

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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	$ 5,071,063	1
2	Discounts and Allowances for all Levels	(3,005,295)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,065,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,267,458	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,267,458	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	1,047	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	265,870	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,987	19
20	Radiology and X-Ray	5,917	20
21	Other Medical Services	138,306	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 421,127	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,739	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,739	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending Machine Revenue**	468	28
28a	**Other Revenue**	7,117	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,585	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,770,677	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	901,082	31
32	Health Care	2,160,486	32
33	General Administration	1,580,072	33
	B. Capital Expense		
34	Ownership	913,458	34
	C. Ancillary Expense		
35	Special Cost Centers	1,172,103	35
36	Provider Participation Fee	204,548	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,931,749	40
41	**Income before Income Taxes (line 30 minus line 40)****	(161,072)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (161,072)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,383,884	44
45	Private Pay - Net Inpatient Revenue	1,927,395	45
46	Medicare - Net Inpatient Revenue	(1,445,454)	46
47	Other-(specify) **Managed Care & Hospice**	223,943	47
48	Other-(specify) **Other Patient Revenue**	(24,000)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,065,768	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 & ID Number REGENCY CARE OF STERLING # 0050476 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	1,640	1,854	$ 66,777	$ 36.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,419	7,865	229,418	29.17	3
4	Licensed Practical Nurses	23,287	24,988	664,288	26.58	4
5	CNAs & Orderlies	55,698	59,243	642,112	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,732	4,135	46,156	11.16	8
9	Activity Director					9
10	Activity Assistants	5,009	5,478	71,635	13.08	10
11	Social Service Workers	3,900	4,151	67,428	16.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,209	15,100	170,437	11.29	15
16	Dishwashers					16
17	Maintenance Workers	3,753	3,986	76,487	19.19	17
18	Housekeepers	9,746	10,406	98,921	9.51	18
19	Laundry	3,812	4,123	40,623	9.85	19
20	Administrator	1,646	1,806	86,826	48.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,768	4,120	67,307	16.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,535	1,627	23,683	14.56	31
32	Other Health C: See Sch 20A	4,053	4,715	113,671	24.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,207	153,597	$ 2,465,769 *	$ 16.05	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	176	$ 9,431	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Quarterly	1,940	10(3)	37
38	Nurse Consultant	14	1,789	10(3)	38
39	Pharmacist Consultant	Monthly	9,588	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	50	1,206	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	240	$ 41,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10(3)	50
51	Licensed Practical Nurses	81	6,412	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	81	$ 6,412		53

Facility Name: **REGENCY CARE OF STERLING**
IDPH License ID Number: **0050476**
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 Coordinator	910	1,237	62,247	$ 50.32
Transportation - CNA	1,290	1,513	18,667	$ 12.34
Staffing Coordinator	1,853	1,965	32,757	$ 16.67
Total - Line 32 Other Health Care (specify):	**4,053**	**4,715**	**113,671**	

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Dunk	Administrator	0	$ 86,826
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,826

B. Administrative - Other

Description	Amount
Management Fees Eliminated in Col 7	$ 338,534
Andrew Beyers	4,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 343,134

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C	See Sch 21C	$ 80,143
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 80,143

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,189
Unemployment Compensation Insurance	36,080
FICA Taxes	188,631
Employee Health Insurance	111,281
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	298,851
TOTAL (agree to Schedule V, line 22, col.8)	$ 773,032

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	$ 1,990
Advertising: Employee Recruitment	1,431
Health Care Worker Background Check	1,779
(Indicate # of checks performed 148)	
Patient Background Checks 44	522
Miscellaneous Licenses & Fees	1,778
Miscellaneous Dues & Subscriptions	4,653
IHCA Dues	8,684
Non allowable Dues	(2,768)
Allocated from Mgmt Co	461
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,530

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,409
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,409

**See instructions.

Facility Name: REGENCY CARE OF STERLING
IDPH License ID Number: 0050476
Fiscal Year End: 12/31/18

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
SB2 Inc	Legal	9,750
Monthly Accruals	Bookkeeping & Accounting	12,000
Paylocity	Payroll Processing	18,400
Knightcare Management	Other Professional Services	20,000
Rockford Urological Associates	Other Professional Services	31
Cardiovascular Medicine	Other Professional Services	54
CGH Medical Center	Other Professional Services	2,772
CGH Main Clinic	Other Professional Services	3,083
KSB	Other Professional Services	79
Rockford Orthopaedic Associates	Other Professional Services	195
Orthopaedic Specialists	Other Professional Services	113
Apria Healthcare	Other Professional Services	1,480
O'Hagan/Meyer	Legal	2,457
Polsinelli Shughart	Legal	9,517
Ogletree, Deakins, Nash, Smoak	Legal	335
Williams Mullen	Legal	(123)
	Total (agree to Schedule V, line 19, column 3)	80,143
Allocated from Management Company	Legal Fees	
Allocated from Management Company	Professional Services	12,980
Less: Non-Allowable Legal Fees		(3,830)
	Total (agree to Schedule V, line 19, column 8)	89,293

Facility Name & ID Number REGENCY CARE OF STERLING # 0050476 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 - $8,684**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,192** Line **10(2)**

(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. $ **204,548**
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. $ **1,047**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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.