		FOR BHF USE			

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0050476

Facility Name: Regency Care of Sterling

Address: 612 West St Marys St (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	PROPRIETARY	GOVERNMENTAL
[ ] 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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	130	Skilled (SNF)	130	47,580	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	47,580	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,768	3,810	7,955	21,533	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,768	3,810	7,955	21,533	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.26%

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 8/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/2009 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 3,633

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	152,415	28,121	14,090	194,626		194,626		194,626			1
2	Food Purchase		177,274		177,274		177,274	(504)	176,770			2
3	Housekeeping	100,455	24,650	-	125,105		125,105		125,105			3
4	Laundry	47,283	7,580	-	54,863		54,863		54,863			4
5	Heat and Other Utilities			185,651	185,651		185,651	1,536	187,187			5
6	Maintenance	81,422	39,294	84,035	204,751		204,751	(3,615)	201,136			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	381,575	276,919	283,776	942,270		942,270	(2,583)	939,687			8
	B. Health Care and Programs											
9	Medical Director	-	-	18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,460,360	235,557	556,209	2,252,126		2,252,126	(5,282)	2,246,844			10
10a	Therapy	9,607	-	-	9,607		9,607		9,607			10a
11	Activities	75,283	2,762	18,582	96,627		96,627	(750)	95,877			11
12	Social Services	105,972	-	-	105,972		105,972		105,972			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	1,651,222	238,319	592,791	2,482,332		2,482,332	(6,032)	2,476,300			16
	C. General Administration											
17	Administrative	73,808	-	336,911	410,719		410,719	(296,521)	114,198			17
18	Directors Fees			-								18
19	Professional Services			106,447	106,447		106,447	4,052	110,499			19
20	Dues, Fees, Subscriptions & Promotions			33,818	33,818		33,818	(931)	32,887			20
21	Clerical & General Office Expenses	74,701	34,172	22,343	131,216		131,216	233,413	364,629			21
22	Employee Benefits & Payroll Taxes			805,947	805,947		805,947		805,947			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,692	1,692		1,692	406	2,098			24
25	Other Admin. Staff Transportation		-	19,970	19,970		19,970	6,604	26,574			25
26	Insurance-Prop.Liab.Malpractice			227,726	227,726		227,726	165	227,891			26
27	Other (specify):* **HO Alloc Benefits**			-				29,781	29,781			27
28	**TOTAL General Administration**	148,509	34,172	1,554,854	1,737,535		1,737,535	(23,031)	1,714,504			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,181,306	549,410	2,431,421	5,162,137		5,162,137	(31,646)	5,130,491			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: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,529	68,529		68,529	14,518	83,047			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			70,439	70,439		70,439	36,365	106,804			32
33	Real Estate Taxes			63,009	63,009		63,009	(443)	62,566			33
34	Rent-Facility & Grounds			715,326	715,326		715,326		715,326			34
35	Rent-Equipment & Vehicles			23,894	23,894		23,894	3,845	27,739			35
36	Other (specify):*			-								36
37	TOTAL Ownership			941,197	941,197		941,197	54,285	995,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	134,887	510,842	645,729		645,729	(202,894)	442,835			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			177,055	177,055		177,055		177,055			42
43	Other (specify):* Non-Allowable Cos	-	-	361,477	361,477		361,477	(361,477)				43
44	TOTAL Special Cost Centers		134,887	1,049,374	1,184,261		1,184,261	(564,371)	619,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,181,306	684,297	4,421,992	7,287,595		7,287,595	(541,732)	6,745,863			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: 1/1/2020 Ending: 12/31/2020

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	(504)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,919)	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	13,676	30		9
10	Interest and Other Investment Income	(809)	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	(91)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,191)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(322,500)	43		24
25	Fund Raising, Advertising and Promotional	(10,893)	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	(33,476)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (369,707)		$	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)	(172,025)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (172,025)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (541,732)		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

STATE OF ILLINOIS

See Page 5A

Regency Care of Sterling

ID# 0050476

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology-Other Contracted Services	$ (3,338)	43	1
2	Lab-Contract Services	(14,636)	43	2
3	Non Allowable dues	(3,734)	20	3
4	Offset Other income	(4,723)	6	4
5	Offset Other income	(5,282)	10	5
6	Offset Other income	(750)	11	6
7	Offset Other income	(35)	21	7
8	Offset Other income	(41)	26	8
9	Offset Other income	(100)	43	9
10	Non-Allowable HO Expenses	(394)	43	10
11	Adjust Real Estate Taxes	(443)	33	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**	(33,476)		49

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			$			$	$ * 0	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: 1/1/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	WW Healthcare Consultants, LLC	100.00%	$ 1,536	$ 1,536	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	1,108	1,108	16
17	V	17	Management Fees	296,521	WW Healthcare Consultants, LLC	100.00%	0	(296,521)	17
18	V	19	Legal Fees		WW Healthcare Consultants, LLC	100.00%	6,066	6,066	18
19	V	19	Accounting Fees		WW Healthcare Consultants, LLC	100.00%	3,177	3,177	19
20	V	20	Licenses		WW Healthcare Consultants, LLC	100.00%	843	843	20
21	V	21	Salaries / Wages		WW Healthcare Consultants, LLC	100.00%	192,776	192,776	21
22	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	26,322	26,322	22
23	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	16,310	16,310	23
24	V	24	Travel & Seminars		WW Healthcare Consultants, LLC	100.00%	406	406	24
25	V	25	Other Admin Staff Transportation		WW Healthcare Consultants, LLC	100.00%	3,524	3,524	25
26	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	206	206	26
27	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	29,781	29,781	27
28	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	842	842	28
29	V	32	Interest	69,418	WW Healthcare Consultants, LLC	100.00%	106,592	37,174	29
30	V	35	Equipment Rent		WW Healthcare Consultants, LLC	100.00%	3,845	3,845	30
31	V	43	Other Costs		WW Healthcare Consultants, LLC	100.00%	394	394	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 365,939			$ 393,728	$ * 27,789	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: 1/1/2020 Ending: 12/31/2020

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	$ 85,788	SCK Assurance LLC		$ 85,788	$	15
16	V	22	Employee Benefits - Health Insurance	54,915	SCK Assurance LLC		54,915		16
17	V	26	Insurance - RAC Audit	14,165	SCK Assurance LLC		14,165		17
18	V	26	Insurance - Gen & Prof Liability	169,416	SCK Assurance LLC		169,416		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			$ 324,284			$ 324,284	$ * 0	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: 1/1/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Other Admin Staff Transportation	$ 3,080	DMG Aero		$ 6,160	$ 3,080	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			$ 3,080			$ 6,160	$ * 3,080	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: 1/1/2020 Ending: 12/31/2020

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	$ 288,277	AdaptNC, LLC		$ 200,986	$ (87,291)	15
16	V	39	Occupational Therapy	254,429	AdaptNC, LLC		177,388	(77,041)	16
17	V	39	Speech Therapy	127,350	AdaptNC, LLC		88,788	(38,562)	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			$ 670,056			$ 467,162	$ * (202,894)	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: 1/1/2020 Ending: 12/31/2020

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	26	Insurance	$ 12,486	T&C Reinsurance Protected Cell Company, LTD		$ 12,486	$	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			$ 12,486			$ 12,486	$ * 0	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: 1/1/2020 Ending: 12/31/2020

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 Black Mountain	North Carolina	Sterling Cottages LLC	Sterling, IL	Independent Liv.	1
2			Regency Care of Mount Sterling	Kentucky	Morris Cottages LLC	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 LL(	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 Cons	Hickory, NC	Mgmt Co.	7
8			(DBA Regency Care of Copley)		Regency Memory Car	Mount Sterling, KY	Assisted Living	8
9					AdaptNC, LLC	North Carolina	Therapy	9
10					T&C Reinsurance Pro	Norcross, GA	Insurance Co.	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: 1/1/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3	No owners receive compensation from this facility.										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 Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	266,620	9	$ 19,023	$	21,533	$ 1,536	1
2	6	Maintenance & Repair - Other	Patient Days	266,620	9	13,717		21,533	1,108	2
3	19	Legal Fees	Patient Days	266,620	9	75,111		21,533	6,066	3
4	19	Accounting Fees	Patient Days	266,620	9	39,335		21,533	3,177	4
5	20	Licenses	Patient Days	266,620	9	10,441		21,533	843	5
6	21	Salaries / Wages	Patient Days	266,620	9	2,386,940	2,386,940	21,533	192,776	6
7	21	Clerical/General-Other	Patient Days	266,620	9	325,921		21,533	26,322	7
8	21	Office/Other Supplies	Patient Days	266,620	9	201,952		21,533	16,310	8
9	24	Travel & Seminars	Patient Days	266,620	9	5,021		21,533	406	9
10	25	Other Admin Staff Transportatio	Patient Days	266,620	9	43,639		21,533	3,524	10
11	26	Insurance	Patient Days	266,620	9	2,552		21,533	206	11
12	27	Employee Benefits	Patient Days	266,620	9	368,741		21,533	29,781	12
13	30	Depreciation	Patient Days	266,620	9	10,427		21,533	842	13
14	32	Interest	Patient Days	266,620	9	1,046		21,533	84	14
15	35	Equipment Rent	Patient Days	266,620	9	47,609		21,533	3,845	15
16	43	Other Costs	Patient Days	266,620	9	4,876		21,533	394	16
17										17
18	32	Interest	Direct Cost						106,508	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,556,352	$ 2,386,940		$ 393,728	25

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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			$	$		$ 85,788	1
2	22	Employee Benefits - Health Insur	Direct Cost						54,915	2
3	26	Insurance-RAC Audit	Direct Cost						14,165	3
4	26	Insurance-Gen & Prof Liability	Direct Cost						169,416	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					$	$		$ 324,284	25

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 Transportatio	Direct Cost			$	$		$ 6,160	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					$	$		$ 6,160	25

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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			$	$		$ 200,986	1
2	39	Occupational Therapy	Direct Cost						177,388	2
3	39	Speech Therapy	Direct Cost						88,788	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					$	$		$ 467,162	25

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: T&C Reinsurance Protected Cell Company, LTI
Street Address: 3740 DaVinci Ct, Ste 130
City / State / Zip Code: Norcross, GA 30092
Phone Number: (770) 246-8535
Fax Number: (770) 246-8536

	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	26	Insurance	Direct Cost			$	$		$ 12,486	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 12,486	25

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10								WW Healthcare Int Exp Adj			69,418	10
11								Offset Interest			(809)	11
12								Finance Charges			1,021	12
13								Allocated from Home Office			37,174	13
14	TOTAL Non-Facility Related						$	$			$ 106,804	14
15	TOTALS (line 9+line14)						$	$			$ 106,804	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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

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

Line	Description		Amount	
1	1. Real Estate Tax accrual used on 2019 report.		$ 60,000	1
2	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.)	2019	$ 61,266	2
3	3. Under or (over) accrual (line 2 minus line 1).		$ 1,266	3
4	4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,300	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 62,566	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	278,221	8
	2016	277,467	9
	2017	275,549	10
	2018	273,143	11
	2019	61,266	12

RE Tax Bill $61,266 X 1.00% = $61,300

FOR BHF USE ONLY

Line	Description	Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-151-005	Long Term Care Property	$ 61,265.92	$ 61,265.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,265.92	$ 61,265.92

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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:

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: 1/1/2020 Ending: 12/31/2020

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	130			2019	$ 109,800	$ 2,745	40	$ 2,745	$	$ 4,118	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing			2009	5,076	338	15	339	1	3,814	9
10	Plumbing			2010	7,897	329	10	328	(1)	7,897	10
11	Mixing Valves			2009	3,305		15	220	220	2,457	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	4,465	15
16	TD Kurtz glass new door			2011	9,297	465	20	464	(1)	4,408	16
17	Repairs-Carpet Service			2011	2,729		20	136	136	1,292	17
18	Repairs-Site inspection			2011	8,446		20	422	422	4,009	18
19	Repairs-Roofing power			2011	2,910		20	146	146	1,387	19
20											20
21	New Heat Exchanger			2013	8,700	870	10	870		6,525	21
22	Replace Existing Water Soure Heat Pumps			2013	48,785	4,879	10	4,879	1	36,592	22
23	HVAC			2013	2,500		10	250	250	1,875	23
24	Interior Design Fee			2013	4,400		10	440	440	3,300	24
25											25
26	New Phones and Phone System-Entire Facility			2014	17,468	1,747	10	1,747	0	11,355	26
27	New Roof			2014	174,900	17,490	10	17,490		113,685	27
28	New AO Smith 100 Gallon Hot Water Heater			2014	3,996		10	400	400	2,600	28
29	Install new outside condensing unit			2014	3,800		10	380	380	2,470	29
30	Repair for 2 Generators			2014	2,533		10	253	253	1,645	30
31											31
32	Remove Condensor from 400 wing and install new			2015	2,595		10	260	260	1,429	32
33											33
34	B&A Glass Retaining Wall outside of 300 hall on southeast			2016	6,250	313	20	313		1,408	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: 1/1/2020 Ending: 12/31/2020

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	12,535	12,535	250,805	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	2,658	2,658	53,123	41
42	Rooms - Villa Hall								42
43									43
44	Phone and Parking Lot Light Repairs	2016	10,000	1,000	10	1,000		4,500	44
45	New water heater in mechanical room	2018	7,669	767	10	767	(0)	2,102	45
46	Paving parking lot and fixing holes	2018	19,880	2,485	8	2,486	1	6,181	46
47									47
48	Furnish and Install Wander Management System for Resident Tra(	2019	21,086	2,109	10	2,109	(0)	3,345	48
49	- Replace Flooring and Guards & Painting After System Installation								49
50	Vinyl Plank Floor for Therapy	2019	9,572	957	10	957	0	1,315	50
51	HVAC Unit for entire building	2019	11,120	1,112	10	1,112		1,557	51
52	Furnish and Install Hot Water Heater	2019	8,884	888	10	888	0	1,554	52
53									53
54	Furnish and Install Water Softener for Entire Building	2020	15,125	1,236	10	1,236		1,236	54
55	Replace Window Coverings Throughout Entire Building	2020	9,350	229	5	229		229	55
56									56
57									57
58									58
59									59
60	Reconcile to book depreciation			3,100			(3,100)		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)		$ 862,160	$ 43,528		$ 58,529	$ 15,001	$ 553,440	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: 1/1/2020 Ending: 12/31/2020

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	$ 123,306	$ 12,425	$ 12,425	$	5-10	$ 93,285	71
72	Current Year Purchases	47,759	4,167	4,167		5-10	4,167	72
73	Fully Depreciated Assets	71,223				5-10	71,223	73
74	Management Company Allocation			842	842			74
75	TOTALS	$ 242,288	$ 16,592	$ 17,434	$ 842		$ 168,675	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	$ 480	$ (480)	5	$ 4,800	76
77	Facility Use	Chevy Van 2002	2015	8,449	1,690	844	(846)	5	8,449	77
78	Facility Use	E-350 Van 2009	2016	24,000	4,800	4,800		5	21,600	78
79	Facility Use	2000 GMC Sierra K2500	2018	4,800	960	960	1	5	3,600	79
80	TOTALS			$ 42,049	$ 8,410	$ 7,084	$ (1,326)		$ 38,449	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)	$ 1,146,497	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,529	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,047	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,518	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 760,564	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number: Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	8/1/2009	$ 715,326			3
4	Additions							4
5								5
6								6
7	TOTAL		130		$ 715,326 **			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.	12/31/2021	$ 720,476
13.	12/31/2022	$ 741,226
14.	12/31/2023	$ 762,573

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: $ 27,739 Description: Nursing Equipment $23,844; Maintenance Equipment $50; HO Allocation $3,845
(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.

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(2),(3),(7)	hrs	$	6,292	$ 134,969	$ 72	6,292	$ 135,041	1
2	Licensed Speech and Language Development Therapist	39(3),(7)	hrs		257	7,852		257	7,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3),(7)	hrs		7,824	161,260	1,420	7,824	162,680	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				131,504		131,504	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Other Professional Ser	39(3)				3,867			3,867	12
13	Other (specify): Respiratory	39(2)					1,891		1,891	13
14	TOTAL			$	14,373	$ 307,948	$ 134,887	14,373	$ 442,835	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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 9,942	$ 9,942	1
2	Cash-Patient Deposits	52,623	52,623	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 502,524)	850,855	850,855	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	6,221	6,221	6
7	Other Prepaid Expenses	106,723	106,723	7
8	Accounts Receivable (owners or related parties)	565,378	565,378	8
9	Other(specify): See Schedule 17A	444,144	444,144	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,035,886	$ 2,035,886	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	-	-	13
14	Buildings, at Historical Cost	531,144	862,160	14
15	Leasehold Improvements, at Historical Cost	-	-	15
16	Equipment, at Historical Cost	293,220	284,337	16
17	Accumulated Depreciation (book methods)	(454,354)	(760,564)	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	-	-	22
23	Other(specify): See Schedule 17A	330,754	330,754	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 700,764	$ 716,687	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,736,650	$ 2,752,573	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 257,510	$ 257,510	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	52,623	52,623	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	135,229	135,229	30
31	Accrued Taxes Payable (excluding real estate taxes)	-	-	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,300	61,300	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	520,536	520,536	36
37	See Schedule 17A	4,267,211	4,267,211	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,294,409	$ 5,294,409	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)**	$ 5,294,409	$ 5,294,409	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,557,759)	$ (2,541,836)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,736,650	$ 2,752,573	48

*(See instructions.)

Facility Name: Regency Care of Sterling
IDPH License ID Number: 0050476
Fiscal Year End: 12/31/2020

Schedule 17A

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

Description	Operating	After Consolidation
Real Estate Tax Escrow	422,555	422,555
W/H-Group Insurance	9,869	9,869
W/H-Employee Advances	2,272	2,272
Due To/From Employee-Health In	7,888	7,888
Due To/From SCK	944	944
Due to / from Symetra	616	616
Total - Line 9	**444,144**	**444,144**

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

Description	Operating	After Consolidation
Capital Improvements Escrow	260,234	260,234
Deposits-Leases	71,126	71,126
Deposits-Other	(606)	(606)
Total - Line 23	**330,754**	**330,754**

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

Description	Operating	After Consolidation
Accrued PTO	48,069	48,069
HW Checking Account	56,489	56,489
PTO Reserve Account	(14,174)	(14,174)
Health Savings Account	206	206
RC Benefits Liability Fund	58,087	58,087
Real Estate Taxes	61,300	61,300
General/Property/Liability Ins	10,752	10,752
Retro Revenue Reserve	12,718	12,718
Suspense	(15,115)	(15,115)
Contingent Liability-PPP	577,600	577,600
Cont Liability-PPP Reserve Acc	(389,880)	(389,880)
Contingent Liability-Stimulus	510,069	510,069
Cont Liability-Stimulus Reserv	(334,285)	(334,285)
Contingent Liability-Stimulus1	198,500	198,500
Contingent Liability-Stimulus1 Res	(198,500)	(198,500)
Cont Liability-State Stimulus	61,087	61,087
Cont Liability-State Stim Res	(61,087)	(61,087)
Total - Line 36	**581,836**	**581,836**

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

Description	Operating	After Consolidation
Due To/From Medicare Bad Debt	(102,297)	(102,297)
Due To Medicaid (Credit Bal)	168,384	168,384
Due To/From WWHCC	4,217,111	4,217,111
Due To/From UMR	(31,396)	(31,396)
Reserve for Mcaid/Mcare Audit	15,409	15,409
Total - Line 37	**4,267,211**	**4,267,211**

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,763,624)	1
2	Restatements (describe):		2
3	Changes in Equity	593,346	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,170,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(387,481)	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)**	$ (387,481)	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)**	$ (2,557,759)	24 *

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

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,156,389	1
2	Discounts and Allowances for all Levels	(1,310,182)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,846,207	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	2,789,096	6
7	Oxygen	-	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,789,096	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	982,799	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	232,293	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	13,573	19
20	Radiology and X-Ray	4,441	20
21	Other Medical Services	19,461	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,252,567	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	809	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 809	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Machine Revenue	504	28
28a	Other Revenue	10,931	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,435	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,900,114	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	942,270	31
32	Health Care	2,482,332	32
33	General Administration	1,737,535	33
	B. Capital Expense		
34	Ownership	941,197	34
	C. Ancillary Expense		
35	Special Cost Centers	1,007,206	35
36	Provider Participation Fee	177,055	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,287,595	40
41	**Income before Income Taxes (line 30 minus line 40)****	(387,481)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (387,481)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,777,908	44
45	Private Pay - Net Inpatient Revenue	1,292,164	45
46	Medicare - Net Inpatient Revenue	(256,863)	46
47	Other-(specify) Managed Care & Hospice	228,231	47
48	Other-(specify) Other Patient Revenue	(195,233)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,846,207	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: 1/1/2020 Ending: 12/31/2020

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,939	1,939	$ 65,262	$ 33.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,043	4,531	148,677	32.82	3
4	Licensed Practical Nurses	19,287	20,773	622,202	29.95	4
5	CNAs & Orderlies	29,591	34,008	529,812	15.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	611	635	9,607	15.14	8
9	Activity Director					9
10	Activity Assistants	4,916	5,325	75,283	14.14	10
11	Social Service Workers	4,429	4,446	105,972	23.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,710	13,136	152,415	11.60	15
16	Dishwashers					16
17	Maintenance Workers	3,497	3,664	81,422	22.22	17
18	Housekeepers	7,721	8,487	100,455	11.84	18
19	Laundry	3,740	4,051	47,283	11.67	19
20	Administrator	1,537	1,537	73,808	48.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,730	4,000	74,701	18.67	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	759	765	9,918	12.97	31
32	Other Health Ca See SCH 20A	3,096	3,732	84,489	22.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,608	111,028	$ 2,181,306 *	$ 19.65	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	233	$ 13,865	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Quarterly	1,685	10(3)	37
38	Nurse Consultant	6	810	10(3)	38
39	Pharmacist Consultant	Monthly	6,557	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	53	3,604	11(3)	44
45	Social Service Consultant				45
46	Other(specify) Interim DON	79	3,236	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	371	$ 47,757		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	865	$ 36,586	10(3)	50
51	Licensed Practical Nurses	964	52,302	10(3)	51
52	Certified Nurse Assistants/Aides	11,739	400,417	10(3)	52
53	TOTAL (lines 50 - 52)	13,568	$ 489,305		53

Facility Nam Regency Care of Sterling
IDPH Licens 0050476
Fiscal Year I 12/31/2020

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	1,608	1,618	46,221	$ 28.57
Staffing Coordinator	1,476	2,102	38,151	$ 18.15
Central Supply	12	12	117	$ 9.75
Total - Line 32 Other Health Care (specify):	**3,096**	**3,732**	**84,489**	

Facility Name & ID Number Regency Care of Sterling # 0050476 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trimane Goddard	Administrator	0	$ 37,946
Katheryn May	Administrator	0	35,862
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,808

B. Administrative - Other

Description	Amount
Management Fees Eliminated in Col 7	$ 296,521
Rebecca Cooley - Contracted Administrator	40,390
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 336,911

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21C	See Sch 21C	$ 106,447
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 106,447

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,294
Unemployment Compensation Insurance	25,063
FICA Taxes	166,870
Employee Health Insurance	341,322
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	165,398
TOTAL (agree to Schedule V, line 22, col.8)	$ 805,947

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	6,712
Health Care Worker Background Check	
(Indicate # of checks performed 196)	1,960
Patient Background Checks 87	1,046
Health Care Council of Illinois	1,617
Miscellaneous Dues & Subscriptions	11,949
IHCA Dues	10,504
Non allowable Dues	(3,734)
Allocated from Mgmt Co	843
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,887

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,692
Allocated from Home Office	406
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,098

**See instructions.

Facility Name: **Regency Care of Sterling**
IDPH License ID Number: **0050476**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
SB2 Inc	Consultant	40,593
O'Hagan Meyer, LLC	Legal	3,086
Monthly Accruals	Bookkeeping & Accounting	6,000
RSM US LLP	Accounting	8,125
Paylocity	Payroll Processing	18,206
Paycom	Payroll Processing	1,034
Beth McCarty	HR Consultant	10,339
RE/MAX	Realtor	725
Polsinelli Shughart	Legal	17,858
John R. Griffin, P.L.L.C.	Legal	481
	Total (agree to Schedule V, line 19, column 3)	106,447
Allocated from Management Company	Legal Fees	6,066
Allocated from Management Company	Professional Services	3,177
Less: Non-Allowable Legal Fees		(5,191)
	Total (agree to Schedule V, line 19, column 8)	110,499

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 - $10,504**

(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. $ **21,188** 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. $ **177,055**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **504**

(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.