FOR BHF USE

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

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: 0053371

Facility Name: Regency Care

Address: 2120 W Washington St (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: (217)793-4880 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: Feb 2015

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: Dave Underwood **Telephone Number:** 309 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 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) David M Underwood
(Title) EVP & CFO

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,464	5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	2,686	20,932	4,366	27,984	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		522		522	12
13	DD 16 OR LESS					13
14	TOTALS	2,686	21,454	4,366	28,506	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.67%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 2/1/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 95 and days of care provided 4,366

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	250,745	13,471		264,216		264,216	5,179	269,395			1
2	Food Purchase		255,453		255,453		255,453		255,453			2
3	Housekeeping	82,744	45,927		128,671		128,671	37	128,708			3
4	Laundry	41,231	13,718		54,949		54,949		54,949			4
5	Heat and Other Utilities			151,891	151,891		151,891	1,609	153,500			5
6	Maintenance	92,770	40,003	117,238	250,011		250,011	21,668	271,679			6
7	Other (specify):*											7
8	TOTAL General Services	467,490	368,572	269,129	1,105,191		1,105,191	28,493	1,133,684			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,772,288	220,852	79,523	2,072,663		2,072,663	318	2,072,981			10
10a	Therapy		742,916	22,322	765,238	(765,238)						10a
11	Activities	68,213	3,988		72,201		72,201		72,201			11
12	Social Services	42,170		5,789	47,959		47,959		47,959			12
13	CNA Training							1,276	1,276			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,882,671	967,756	149,634	3,000,061	(765,238)	2,234,823	1,594	2,236,417			16
	C. General Administration											
17	Administrative	108,870			108,870		108,870		108,870			17
18	Directors Fees											18
19	Professional Services			410,918	410,918		410,918	(385,872)	25,046			19
20	Dues, Fees, Subscriptions & Promotions			235,250	235,250	(195,449)	39,801	(8,517)	31,284			20
21	Clerical & General Office Expenses	380,811	38,311	22,758	441,880		441,880	302,416	744,296			21
22	Employee Benefits & Payroll Taxes			485,555	485,555		485,555	40,813	526,368			22
23	Inservice Training & Education			11,600	11,600		11,600	1,251	12,851			23
24	Travel and Seminar			3,368	3,368		3,368	1,631	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,390	55,390		55,390	17,121	72,511			26
27	Other (specify):* Lost resident items			34,127	34,127		34,127	(33,525)	602			27
28	TOTAL General Administration	489,681	38,311	1,258,966	1,786,958	(195,449)	1,591,509	(64,682)	1,526,827			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,839,842	1,374,639	1,677,729	5,892,210	(960,687)	4,931,523	(34,595)	4,896,928			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 #0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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							299,029	299,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							240,750	240,750			32
33	Real Estate Taxes							115,376	115,376			33
34	Rent-Facility & Grounds			622,750	622,750		622,750	(616,634)	6,116			34
35	Rent-Equipment & Vehicles			12,450	12,450		12,450	9,218	21,668			35
36	Other (specify):*											36
37	**TOTAL Ownership**			635,200	635,200		635,200	47,739	682,939			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			842,613	842,613	765,238	1,607,851		1,607,851			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					195,449	195,449		195,449			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			842,613	842,613	960,687	1,803,300		1,803,300			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,839,842	1,374,639	3,155,542	7,370,023		7,370,023	13,144	7,383,167			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 # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(672)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,829)			19
20	Contributions	(3,525)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,174)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)			24
25	Fund Raising, Advertising and Promotional	(18,401)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,601)		$	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)	79,745		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,745		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,144		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Regency Care

ID# 0053371

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(3,525)	27	20
21				21
22		(9,174)	19	22
23				23
24		(30,000)	27	24
25		(18,401)	20	25
26				26
27		0	22	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**	(61,100)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Care # 0053371 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	5,179	0	0	0	0	0	0	0	0	5,179	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	37	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,609	0	0	0	0	0	0	0	0	1,609	5
6	Maintenance	0	0	21,668	0	0	0	0	0	0	0	0	21,668	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	28,493	0	0	0	0	0	0	0	0	28,493	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	318	0	0	0	0	0	0	0	0	318	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,276	0	0	0	0	0	0	0	0	1,276	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	1,594	0	0	0	0	0	0	0	0	1,594	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,174)	(396,553)	19,855	0	0	0	0	0	0	0	0	(385,872)	19
20	Fees, Subscriptions & Promotions	(18,401)	0	9,884	0	0	0	0	0	0	0	0	(8,517)	20
21	Clerical & General Office Expenses	0	0	302,416	0	0	0	0	0	0	0	0	302,416	21
22	Employee Benefits & Payroll Taxes	0	0	40,813	0	0	0	0	0	0	0	0	40,813	22
23	Inservice Training & Education	0	0	1,251	0	0	0	0	0	0	0	0	1,251	23
24	Travel and Seminar	(4,829)	0	6,460	0	0	0	0	0	0	0	0	1,631	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	17,121	0	0	0	0	0	0	0	0	17,121	26
27	Other (specify):*	(33,525)	0	0	0	0	0	0	0	0	0	0	(33,525)	27
28	**TOTAL General Administration**	(65,929)	(396,553)	397,800	0	0	0	0	0	0	0	0	(64,682)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,929)	(396,553)	427,887	0	0	0	0	0	0	0	0	(34,595)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Care # 0053371 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	270,871	0	28,158	0	0	0	0	0	0	0	299,029	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(672)	241,120	0	302	0	0	0	0	0	0	0	240,750	32
33	Real Estate Taxes	0	115,376	0	0	0	0	0	0	0	0	0	115,376	33
34	Rent-Facility & Grounds	0	(622,750)	0	6,116	0	0	0	0	0	0	0	(616,634)	34
35	Rent-Equipment & Vehicles	0	0	0	9,218	0	0	0	0	0	0	0	9,218	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(672)	4,617	0	43,794	0	0	0	0	0	0	0	47,739	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,601)	(391,936)	427,887	43,794	0	0	0	0	0	0	0	13,144	45

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
Rutledge Joint Ventures LLC	99%	Heritage Health - Springfield	Springfield	Rutledge-Regency Rea	Springfield	Real Estate Holding
Rutledge - Regency Holdings LLC	1%			Heritage Operations G	Bloomington	Mgmt

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Adjustment for Related Organiza	$ 396,553	Heritage Operations Group LLC	0.00%	$	$ (396,553)	1
2	V	34	Adjustment for Related Organization	622,750	Rutledge-Regency Real Estate LLC	0.00%		(622,750)	2
3	V								3
4	V	33	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	115,376	115,376	4
5	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	239,472	239,472	5
6	V	30	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	270,871	270,871	6
7	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	1,648	1,648	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,019,303			$ 627,367	$ * (391,936)	14

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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	1	Dietary	$	Heritage Operations Group LLC		$	$ 5,179	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					37	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,609	19
20	V	6	Maintenance					21,668	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					318	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,276	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					19,855	31
32	V	20	Fees, Subscription, Promotions					9,884	32
33	V	21	Clerical & General Office Expenses					302,416	33
34	V	22	Employee Benefits & Payroll Taxes					40,813	34
35	V	23	Inservice Training & Education					1,251	35
36	V	24	Travel and Seminar					6,460	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26						17,121	38
39	Total			$			$ 0	$ * 427,887	39

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. ☐ 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	27	Other	$	Heritage Operations Group LLC		$	$ 0	15
16	V	30	Depreciation					28,158	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					302	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,116	20
21	V	35	Rent-Equipment & Vehicles					9,218	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	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			$			$ 0	$ * 43,794	39

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	No Compensation to Owners								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: Heritage Operations Group
Street Address: Box 3188
City / State / Zip Code: Bloomington, IL 61701
Phone Number: ( )
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	1	Dietary	Beds	2,571	26	$ 134,491	$ 133,835	99	$ 5,179	1
2	2	Food Purchase	Beds	2,571	26	0	0	99	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	99	37	3
4	4	Laundry	Beds	2,571	26	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	99	1,609	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	99	21,668	6
7	7	Other	Beds	2,571	26	0	0	99	0	7
8	9	Medical Director	Beds	2,571	26	0	0	99	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	99	318	9
10	11	Activities	Beds	2,571	26	0	0	99	0	10
11	12	Social Service	Beds	2,571	26	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	99	1,276	12
13	14	Program Transportation	Beds	2,571	26	0	0	99	0	13
14	15	Other	Beds	2,571	26	0	0	99	0	14
15	17	Administrative	Beds	2,571	26	0	0	99	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	99	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	99	19,855	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	99	9,884	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	99	302,416	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,571	26	1,059,901	0	99	40,813	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	99	1,251	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	99	6,460	22
23	25	Other Admin. Staff Transportatio	Beds	2,571	26	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	99	17,121	24
25	TOTALS					$ 11,112,081	$ 7,666,930		$ 427,887	25

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 See Pg 8
Street Address
City / State / Zip Code
Phone Number ( )
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	27	Other	Beds	2,571	26	$	$	99	$	1
2	30	Depreciation	Beds	2,571	26	731,247		99	28,158	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			99		3
4	32	Interest	Beds	2,571	26	7,851		99	302	4
5	33	Real Estate Taxes	Beds	2,571	26			99		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		99	6,116	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		99	9,218	7
8	36	Other	Beds	2,571	26			99		8
9	38	Medically Nec Transportation	Beds	2,571	26			99		9
10	39	Ancillary Service Centers	Beds	2,571	26			99		10
11	40	Barber and Beauty Shops	Beds	2,571	26			99		11
12	41	Coffee and Gift Shops	Beds	2,571	26			99		12
13	42	Other	Beds	2,571	26			99		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					$ 1,137,301	$		$ 43,794	25

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Lancaster-Pollard		x	Mortgage			$	$			$ 239,472	1
2											1,648	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 241,120	9
	B. Non-Facility Related*											
10	Interest Income										(672)	10
11	Central Office Allocation										302	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (370)	14
15	TOTALS (line 9+line14)						$	$			$ 240,750	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 30,779 Line # 32

*** 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 # 0053371 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 115,376	2
3. Under or (over) accrual (line 2 minus line 1).		$ 115,376	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 115,376	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013		10
2014	113,647	11
2015	115,376	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Care COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0053371

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14320101024		$ 115,375.22	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 115,375.22	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,262 B. General Construction Type: Exterior Brick & Vinyl Frame Sheet Metal Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2015	$ 620,000	1
2					2
3	TOTALS			$ 620,000	3

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	99		2015		$ 7,466,301	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Cabling for new IT systems			2015	40,016						10
11	Phone system installation			2015	28,951						11
12	Install (2) water heaters			2015	4,192						12
13	Install new freezer			2015	4,961						13
14	Install (2) new temering replacement valves			2015	3,284						14
15	Rebuild roof where splits occurred			2015	9,074						15
16											16
17	Install new water heater			2016	18,700						17
18	Install tile flooring - Various corridors, nurses stations and specific reside			2016	63,430						18
19	rooms in the East, West and Center wings (Wings map attached)										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	C/O Allocation					28,158		28,158			33
34	Book Depreciation					199,060		199,060			34
35											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 # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									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)		$ 7,638,909	$ 227,218		$ 227,218	$	$	70

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 386,530	$ 68,246	$ 68,246	$		$	71
72	Current Year Purchases	75,714						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 462,244	$ 68,246	$ 68,246	$		$	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	Resident transports	2016 Ford E350	2016	$ 59,887	$ 3,565	$ 3,565	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 59,887	$ 3,565	$ 3,565	$		$	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)	$ 8,781,040	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 299,029	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 299,029	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 622,750	27		3
4	Additions							4
5								5
6								6
7	TOTAL				$ 622,750 **			7

10. Effective dates of current rental agreement:
Beginning 2-1-2015
Ending 5-1-2042

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

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: $ 12,450 Description: Televisions
(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	None		$	$	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 # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 ☐ NO

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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		hrs	$		$ 403,066	$		$ 403,066	1
2	Licensed Speech and Language Development Therapist		hrs			66,190			66,190	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			373,357	0		373,357	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				742,916		742,916	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					22,322			22,322	13
14	TOTAL			$		$ 864,935	$ 742,916		$ 1,607,851	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.

STATE OF ILLINOIS

Facility Name & ID Number Regency Care # 0053371 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 1,266,217	$	1
2	Cash-Patient Deposits	6,174		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	588,244		3
4	Supply Inventory (priced at)	52,092		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,214		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	197,155		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,129,096	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,129,096	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 386,609	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,174		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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	Bed Tax	23,157		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 415,940	$	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)**	$ 415,940	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,713,156	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,129,096	$	48

***(See instructions.)**

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 978,152	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 978,152	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	735,004	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)**	$ 735,004	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,713,156	24 *

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,863,363	1
2	Discounts and Allowances for all Levels	(3,481,252)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,382,111	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,325,979	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,325,979	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,410,020	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(13,755)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,396,265	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	672	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 672	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,105,027	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,105,191	31
32	Health Care	3,000,061	32
33	General Administration	1,786,958	33
	B. Capital Expense		
34	Ownership	635,200	34
	C. Ancillary Expense		
35	Special Cost Centers	842,613	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,370,023	40
41	**Income before Income Taxes (line 30 minus line 40)****	735,004	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 735,004	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	1,801	1,896	$ 68,948	$ 36.36	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,112	7,486	242,878	32.44	3
4	Licensed Practical Nurses	21,349	22,473	537,658	23.92	4
5	CNAs & Orderlies	59,597	62,734	849,025	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,641	4,885	73,779	15.10	8
9	Activity Director					9
10	Activity Assistants	4,923	5,182	68,213	13.16	10
11	Social Service Workers	1,835	1,932	42,170	21.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,668	19,651	250,745	12.76	15
16	Dishwashers					16
17	Maintenance Workers	6,186	6,512	92,770	14.25	17
18	Housekeepers	8,944	9,415	82,744	8.79	18
19	Laundry	4,020	4,232	41,231	9.74	19
20	Administrator	1,984	2,088	108,870	52.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,275	17,132	380,811	22.23	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,335	165,618	$ 2,839,842 *	$ 17.15	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		$ 0		35
36	Medical Director		42,000		36
37	Medical Records Consultant		2,080		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,621		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,789		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 55,490		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 1,075	10,3	50
51	Licensed Practical Nurses		70,228	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 71,303		53

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Twardowski			$ 108,870
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,870

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 392,533
ADP	Payroll Tax Processing	911
Sulaski & Webb	Audit & Tax	6,000
Michigan Peer Review	Consulting	540
McKee Environmental	Asbestos Sampling	1,760
Legal adj to Zero		9,174
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 410,918

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,888
Unemployment Compensation Insurance	29,227
FICA Taxes	217,248
Employee Health Insurance	131,727
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	17,465
Central Office Allocation	40,813
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,368

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,351
Health Care Worker Background Check	
(Indicate # of checks performed)	3,225
PR	14,679
Dues & Subscriptions	3,531
License & Fees	1,022
Central Office Allocation	9,884
Less: Public Relations Expense	(14,679)
Non-allowable advertising	(729)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,284

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,410
	7
Seminar Expense	1,951
	1,631
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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? **No**
If YES, give association name and amount.

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **52,155**
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? Indicate the amount. $ **2,294**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sulaski & Webb**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009			PETTY CASH	1,266,217							
1010			CASH IN BANK								
1040			CASH IN BANK-PAYROLL								
1100			ACCOUNTS RECEIVABLE	588,244							
1110			MEDICARE RECEIVABLES								
1125			IPA INCOME RECEIVABLE								
1130			MEDICARE COST REPORT								
1135			ACCOUNTS RECEIVABLE-IC								
1140			UNAPPLIED CASH RECEIPTS								
1145			A/R SUSPENSE-REFUNDS								
1190			ACCRUED INTEREST REC								
1200			PREPAID INSURANCE	19,214							
1220			OTHER PREPAID EXPENSES								
1300			FOOD INVENTORY								
1310			SUPPLIES INVENTORY	52,092							
1409			LAND	0							
1450			FURNITURE & EQUIPMENT	0							
1460			ACCUM DEPR-FURN & EQUI	0							
1475			BUILDING & IMPROVEMEN	0							
1490			ACCUM DEPR-BUILDING	0							
1530			RESIDENT FUNDS	6,174							
1550			LOAN FEES	0							
1560			REAL ESTATE TAX ESCROW								
1575			REIMBURSABLE PURCHASES								
1850			INTRACOMPANY	197,155							
2010			ACCOUNTS PAYABLE	-386,609							
2095			BONUSES PAYABLE								
2100			ACCRUED PAYROLL	0							
2110			ACCRUED VACATION PAY	0							
2120			UC TAXES PAYABLE								
2125			FICA TAX PAYABLE	0	0						
2130			FIT PAYABLE								
2140			STATE W/H PAYABLE		0						
2145			EARNED INCOME CREDIT								
2150			UC FED CREDIT REDUCTION								
2230			PAYROLL SAVINGS								
2235			IRA W/HOLDINGS								
2240			UNITED WAY								
2245			GROUP INSURANCE PAYABLE								
2246			GROUP INSURANCE PAYABLE-CAFETERIA								
2260			WAGE GARNISHMENTS								
2280			MISC PAYROLL DEDUCTIONS								
2300			ACCRUED INTEREST PAYAI	0							
2310			SALES TAX PAYABLE								
2320			IPA PAYMENTS PAYABLE	-23,157							
2350			REAL ESTATE TAX PAYABL	0							
2385			ACTIVITY FUND	0							
2390			SECURITY DEPOSITS	0							
2391			VOLUNTEER FUND								
2393			HEART FUND/BAZAAR								
2395			DEFERRED INC EMP & MEM								
2400			CURRENT PORTION LT DEBT								
2460			INCOME TAXES PAYABLE								
2512			DUE TO RESIDENTS	-6,174							
2600			MORTGAGE PAYABLE	0							
2650			EQUIPMENT LOAN PAYABLE								
2695			CURRENT PORTION LT DEBT								
2696			DEFERRED INCOME TAXES								
2710			COMMON STOCK								
2720			RETAINED EARNINGS	-978,152							
2970			PROFIT/LOSS FOR PERIOD	-735,004							
3007.1			PATIENT DAYS-PRIVATE	20,932							
3007.2			PATIENT DAYS-IPA	2,686							
3007.3			PATIENT DAYS-MEDICARE	4,366							
3007.4			PATIENT DAYS-CONVERSION								
3007.5			PATIENT DAYS-LICENSED								
3007.6			PATIENT DAYS-TOTAL								
3010		1	BASIC CHARGE-PRIVATE &	-6,863,363		0	0	0	0		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		
3035		4	DAY CARE/HOME CARE			0	0	0	0		
3040		1	LIGHT NURSING CARE			0	0	0	0		
3050		1	MEDIUM NURSING CARE			0	0	0	0		
3060		1	HEAVY NURSING CARE			0	0	0	0		
3061		1	SKILLED NURSING CARE								
3080		1	NURSING SUPPLIES-PRIVAT	0		0	0	0	0		
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		
3083		1	NURSING SUPPLIES MED PT B								
3100		17	DRUGS	-1,410,020		0	0	0	0		
3101		17	DRUGS-OTHER								
3110		6	PT-PRIVATE	-3,325,979		0	0	0	0		
3111		6	PT-IPA			0	0	0	0		
3112		6	PT-MEDICARE PART A			0	0	0	0		
3113		6	PT-MEDICARE PART B			0	0	0	0		
3130		1	PUBLIC AID ASSESSMENT II								
3140		19	LABORATORY INCOME			0	0	0	0		
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		
3151		6	SPEECH/OT-IPA			0	0	0	0		
3152		6	SPEECH/OT-MED PART A			0	0	0	0		
3153		6	SPEECH/OT MED PART B								
3410		2	IPA DISCOUNTS	3,481,252		0	0	0	0		
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		
3420		2	MEDICARE DISCOUNTS			0	0	0	0		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		
3520		16	RENT INCOME	0		6	0	6	0		
3530		13	BEAUTY SHOP	0		0	0	0	0		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		
3570		12	VENDING INCOME/EXPENSI	0		0	0	0	0		
3580		12	MANAGEMENT FEES			0	0	0	0		
3590		1	EQUIPMENT RENTAL	0		0	0	0	0		
3595		21	RESIDENT TRANSPORTATIC	13,755		0	0	0	0		
3600		21	MISC INCOME	0		0	0	0	0		
4110			GENERAL & ADMINIST WAC	354,501	380,811	21	1	17	0		
4111			ADMINISTRATOR WAGES	108,870	108,870	17	1	0	0		
4115			VACATION & SICK - G&A	26,310		21	1	0	0		
4120	4475		EMPLOYEE BENEFITS	17,465	485,555	22	3	0	0		
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0		
4130			EMPLOYEE SCHOLORSHIP V	0		21	1	0	0		
4135			EMPLOYEE SCHOLORSHIP C	0		23	3	0	0		
4220			DIRECTORS FEES	0	0	18	3	0	0		
4250	4255		OFFICE SUPPLIES	38,311	38,311	21	2	0	0		
4260			TELEPHONE	22,758	22,758	21	3	0	0		
4275			TRAINING & EMPLOYEE DE	11,600	11,600	23	3	16	0	**	
4280			GENERAL TRAVEL	1,410	3,368	24	3	16	0		
4281			MEAL EXPENSE FOR TRAVE	7		24	3	19	0		
4285			EDUCATION & SEMINAR	1,951		24	3	19	-4,829	***	
4290			HELP WANTED ADVERTISIN	14,351	235,250	20	3	0	0		-52,155
4291			PROMOTIONAL ADVERTISII	2,993		20	3	25	-2,993		
4292			PUBLIC RELATIONS	14,679		20	3	25	-14,679		
4300			LICENSES & FEES	196,471		20	3	17	0		
4310			DUES & SUBSCRIPTIONS	3,531		20	3	17	-729		
4320			CONTRIBUTIONS	3,525		27	3	20	-3,525		
4350			PROFESSIONAL FEES	14,365	410,918	19	3	22	-9,174		
4355			MEDICAL DIRECTOR	42,000	42,000	9	3	0	0		
4360			UTILIZATION REVIEW	0		10	3	0	0		
4361			OTHER PHYSICIAN FEES			39	3	0	0		
4362			MEDICAL RECORDS CONSU	2,080		10	3	0	0		
4363			PHARMACIST FEES	5,621		10	3	0	0		
4364			SOC SERV/ACT CONSULT	5,789	5,789	12	3	0	0		
4370			TV RENTAL	12,262		35	3	5	0		
4380			INCOME TAXES		34,127	27	3	26	0		
4383			BACKGROUND CHECKS	3,225		20	3	26	0		
4400			PAYROLL TAXES	235,174		22	3	0	0		
4401			PAYROLL TAXES ADMINIST	11,301		22	3	0	0		
4410			GROUP INSURANCE	131,727		22	3	0	0		
4420			LIABILITY INSURANCE	55,390	55,390	26	3	0	0		
4425			INSURANCE-OWNERS			22	3	21	0		
4430			WORKMENS COMP INSURAI	89,888		22	3	0	0		
4450			CENTRAL OFFICE FEES	396,553		19	3	34	0	**	
4460			BAD DEBTS	30,000		27	3	24	-30,000		
4470			LOST ITEMS-RESIDENTS	602		27	3	0			
4490			MISCELLANEOUS	0		27	3	0	0		
4510			REAL ESTATE TAXES	0	0	33	3	0	0		
4600			LEASED EQUIPMENT	188	12,450	35	3	16	0		
5110			MAINTENANCE SALARIES	87,379	92,770	6	1	0	0		
5120			MAINTENANCE SICK & VAC	5,391		6	1	0	0		
5130			ELECTRIC	110,486	151,891	5	3	0	0		
5131			NATURAL GAS	10,310		5	3	0	0		
5132			HEATING & DEISEL OIL			5	3	0	0		
5133			WATER & SEWER	31,095		5	3	0	0		
5134			TRASH COLLECTION	31,202	117,238	6	3	0	0		
5140			PROPERTY PLANT REPLACE	6,098	40,003	6	2	0	0		
5160			GENERAL REPAIR & MAINT	33,905		6	2	0	0		
5165			MAINTENANCE CONTRACT	86,036		6	3	0	0		
5210			DIETARY WAGES	231,633	250,745	1	1	0	0		
5220			DIETARY SICK & VAC	19,112		1	1	0	0		
5240			SALES TAX			2	3	13	0		
5248			FOOD PURCHASES	257,747	255,453	2	2	0	0		
5250			SUPPLIES-DISHWASHING	2,353	13,471	1	2	0	0		
5260			DIETARY REPLACEMENT	2,468		1	2	0	0		
5270			KITCHEN SUPPLIES-PAPER	8,650		1	2	0	0		
5295			MEAL CREDIT	-2,294		2	2	0	0		
5310			LAUNDRY WAGES	38,947	41,231	4	1	0	0		
5340			LAUNDRY SICK & VAC	2,284		4	1	0	0		
5370			LAUNDRY REPLACEMENT	6,946	13,718	4	2	0	0		
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		
5390			LAUNDRY SUPPLIES	6,772		4	2	0	0		
5410			HOUSEKEEPING WAGES	81,055	82,744	3	1	0	0		
5440			HOUSEKEEPING SICK & VA(	1,689		3	1	0	0		
5480			HOUSEKEEPING SUPPLIES	45,683	45,927	3	2	0	0		
5490			HOUSEKEEPING SUPPLIES-I	244		3	2	0	0		
6010			RN WAGES-MEDICARE		1,772,288	10	1	0	0		
6020			RN WAGES-NON MEDICARE	224,331		10	1	0	0		
6030			DON WAGES	68,948		10	1	0	0		
6035			ADON	0		10	1	0	0		
6040			RN SICK & VACATION	18,547		10	1	0	0		
6110			LPN WAGES-MEDICARE	510,283		10	1	0	0		
6120			LPN WAGES-NON MEDICAR	0		10	1	0	0		
6130			LPN WAGES OTHER			10	1	0	0		
6140			LPN SICK & VACATION	27,375		10	1	0	0		
6210			AIDE WAGES-MEDICARE			10	1	0	0		
6220			AIDE WAGES-NON MEDICAI	816,940		10	1	0	0		
6230			WARD CLERKS			10	1	0	0		
6240			AIDE VACATION & SICK	32,085		10	1	0	0		
6245			CONTRACT NURSES-RN	1,075		10	3	0	0		
6246			CONTRACT NURSES-LPN	70,228		10	3	0	0		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		
6250			NURSE AIDE TRAINING WA	0	0	13	1	0	0		
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		
6260			NURSE AIDE TRAINING REI	0		0	0	0	0		
6270			REHAB WAGES	68,496		10	1	0	0		
6275			REHAB SICK & VAC	5,283		10	1	0	0		
6280			NURSING DEPT EDUCATION			23	3	0	0		
6290			NURSING SUPPLIES	13,474	220,852	10	2	0	0		
6295			NURSING SUPPLIES	145,825		10	2	0	0		
6390			REPLACEMENT-NURSING	61,553		10	2	0	0		
6490			NURSING OTHER	519	79,523	10	3	0	0		
7280			DRUG PURCHASES	414,086	742,916	39	2	0	0	***	
7281			DRUG PURCHASES-OTHER	328,830		39	2				
7380			LABORATORY SERVICES	22,322	864,935	39	3	0	0		
7410			HOME HEALTH SALARY			39	1	0	0		
7440			HOME HEALTH SICK & VAC			39	1	0	0		
7450			HOME HEALTH EXPENSES			39	3	0	0		
7510			ACTIVITES WAGES	63,660	68,213	11	1	0	0		
7540			ACTIVITIES SICK & VAC	4,553		11	1	0	0		
7590			ACTIVITIES SUPPLIES	3,988	3,988	11	2	0	0		
7595			ACTIVITIES FEES	0	0	11	3	0	0		
7610			PT WAGES			39	1	0	0		
7611			PT SICK & VACATION			39	1	0	0		
7620			PT FEES	373,357		39	3	0	0	***	
7660			PT SUPPLIES	0		39	2	0	0		
7710			SOCIAL SERVICE WAGES	38,285	42,170	12	1	0	0		
7720			SOCIAL SERVICE SICK & VA	3,885		12	1	0	0		
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740			OT FEE	403,066		39	3	0	0	***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770			SPEECH THERAPY FEE	66,190		39	3	0	0	***	
7800			BEAUTICIAN WAGES		0	40	1	0	0		
7810			BEAUTICIAN SICK & VAC			40	1	0	0		
7820			BEAUTICIAN FEES	0	0	40	3	0	0		
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910			VOLUNTEER COORDINATOR			21	1	0	0		
7940			VOL COORD SICK & VAC			21	1	0	0		
7960			VOL COORD SUPPLIES	0		21	2	0	0		
8100			RENT	622,750	622,750	34	3	0	0		
8120			INTEREST EXPENSE	0	0	32	3	14	-672		
8130			DEPRECIATION	0	0	30	3	9	0		
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510			INTEREST INCOME	-672		32	0	10	0		
9520			MISC NON-OPERATING INC(	0		0	0	0	0		
9700			INCOME TAXES	0		0	0	0	0		
				7,369,351	7,370,023						
					672						
GRAND TOTALS				-735,004					-66,601		
				(NET INCOME)							
				0							

1,009	1,009	CASH	1,266,217
1,100	1,100	ACCTS RI	643,398
1,101	1,101	ALLOW. I	(55,154)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID	19,214
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY	0
1,310	1,310	SUPPLIES	52,092
1,320	1,320	LINEN IN	0
1,409	1,409	LAND	0
1,450	1,450	FURNITU	0
1,460			0
1,475	1,475	BUILDIN	0
1,490	1,490	ACCUM I	0
1,530	1,530	RESIDEN	6,174
1,550	1,550	LOAN FE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	197,155
2,010	2,010	ACCOUN	(386,609)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	0
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	0
2,120	2,120	U.C. TAX	0
2,125	2,125	FICA TA	0
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	0
2,300	2,300	ACCRUEI	0
2,320	2,320	IPA PAYM	(23,157)
2,350	2,350	REAL EST	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO R	(6,174)
2,600	2,600	LASALLE	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINE	(978,152)
		net income	(735,004)
		balance	0

3,007	3,007	PATIENT DA	20,932
3,007	3,007	PATIENT DA	2,686
3,007	3,007	PATIENT DA	4,366
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHAR	(6,863,363)
3,020	3,020	BASIC CHAR	0
3,030	3,030	BASIC CHAR	0
3,040			0
3,022	3,022	ASSESSMEN	143,294
3,060			0
3,061			0
3,080	3,080	NURSING SU	0
3,081	3,081	NURSING SU	0
3,082	3,082	NURSING SU	0
3,083	3,083	NURSING SU	0
3,100	3,100	DRUGS-MED	(1,410,020)
3,101			0
3,110	3,110	PHYSICAL T	(3,325,979)
3,111			0
3,112	3,112	PHYSICAL T	0
3,113	3,113	PHYSICAL T	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THER	0
3,153	3,153	ST/OT THER	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER D	0
3,411	3,411	MEDICARE F	0
3,420	3,420	MEDICARE D	3,468,689
3,500			
3,520	3,520	RENT INCOM	0
3,530	3,530	BEAUTY SHO	0
3,560			0
3,570	3,570		
3,590	3,590	EQUIPMENT	0
3,595	3,595	RESIDENT TI	13,755
3,600	3,600	MISC INCOM	0
4,110	4,110	G&A WAGES	354,501
4,111	4,111	ADMINISTRA	108,870
4,115	4,115	G&A PTO & I	26,310
4,120	4,120	EMPLOYEE I	17,377
4,121			
4,130	4,130	EMPLOYEE S	0
4,135	4,135	EMPLOYEE S	0
4,250	4,250	OFFICE SUPI	10,596
4,255	4,255	POSTAGE	5,257
4,260	4,260	TELEPHONE	22,758
4,275	4,275	TRAINING &	11,600
4,276			0
4,280	4,280	GENERAL TI	1,410
4,281	4,281	MEAL EXPEI	7
4,285	4,285	EDUCATION	1,642
4,289	4,289	MEETINGS E	309
4,290	4,290	HELP WANT	14,351
4,291	4,291	PROMOTION	2,993
4,292	4,292	PUBLIC REL	14,679
4,300	4,300	LICENSE & F	53,177
4,310	4,310	DUES & SUB	3,531
4,320	4,320	CONTRIBUTI	3,525
4,350	4,350	PROFESSION	14,365
4,355	4,355	MEDICAL DI	42,000
4,362			2,080
4,363			5,621
4,364	4,364	SOCIAL SER	5,789
4,370	4,370	TV RENTAL	12,262
4,383	4,383	BACKGROUI	3,225
4,390	4,390	OTHER TAXI	0
4,400	4,400	PAYROLL TA	235,174
4,401	4,401	PAYROLL TA	11,301
4,410	4,410	GROUP INSU	131,727
4,420	4,420	LIABILITY IN	55,390
4,430	4,430	WORKMAN'S	86,895
4,435	4,435	W/C-FIRST A	0
4,436	4,436	DRUG TESTI	2,993
4,450	4,450	MANAGEME	396,553
4,460	4,460	BAD DEBTS	30,000
4,461	4,461	BAD DEBTS	12,563
4,470	4,470	LOST ITEMS-	602
4,475	4,475	UNIFORM EX	88
4,486	4,486	M.I.S. Softwar	28,311
4,490	4,490	MISC EXPEN	44
4,496	4,496	MISC. M.I.S. I	22,458
4,510	4,510	REAL ESTAT	0
4,600	4,600	LEASED EQU	188
5,110	5,110	MAINTENAN	87,379
5,120	5,120	MAINTENAN	5,391
5,130	5,130	ELECTRIC	110,486
5,131	5,131	NATURAL G.	10,310
5,133	5,133	WATER & SE	31,095
5,134	5,134	TRASH COLI	31,202
5,140	5,140	PROP/PLANT	6,098
5,160	5,160	GENERAL RI	33,905
5,165	5,165	MAINTENAN	57,725
5,210	5,210	DIETARY W/	231,633
5,220	5,220	DIETARY PT	19,112
5,248	5,248	FOOD PURCI	257,703
5,250	5,250	SUPPLIES DI	2,353
5,260	5,260	REPLACEME	2,468
5,270	5,270	KITCHEN SU	8,650
5,295	5,295	MEAL INCO	(2,294)
5,310	5,310	LAUNDRY W	38,947
5,340	5,340	LAUNDRY P	2,284
5,370	5,370	REPLACEME	6,946
5,380			0
5,390	5,390	SUPPLIES	6,772
5,410	5,410	HOUSEKEEP	81,055
5,440	5,440	HOUSEKEEP	1,689
5,480	5,480	SUPPLIES-CI	45,683
5,490	5,490	SUPPLIES-HO	244
6,020	6,020	RN WAGES	224,331
6,030	6,030	DON WAGES	68,948
6,035	6,035	ADON WAGE	0
6,040	6,040	RN PTO & RE	18,547
6,120	6,120	LPN WAGES	510,283
6,140	6,140	LPN PTO & R	27,375
6,220	6,220	AIDES WAGI	816,940
6,240	6,240	AIDES PTO &	32,085
6,245			1,075
6,246			70,228
6,247			
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB WAG	68,496
6,275	6,275	REHAB PTO	5,283
6,290	6,290	NURSING SU	13,474
6,295	6,295	NURSING SU	145,825
6,390	6,390	REPLACEME	61,553
6,490	6,490	OTHER	519
7,280	7,280	DRUG PURCI	414,086
7,281	7,281	DRUG PURCI	328,830
7,380	7,380	LABORATOF	14,485
7,391	7,390	X-RAY SERV	7,837
7,393			
7,510	7,510	ACTIVITIES	63,660
7,540	7,540	ACTIVITIES	4,553
7,590	7,590	ACTIVITIES	3,988
7,620	7,620	PHYSICAL T	373,357
7,660	7,660	P.T. SUPPLY	0
7,710	7,710	SOCIAL SER	38,285
7,720	7,720	SOCIAL SER	3,885
7,730	7,730	SOCIAL SERVICE-EXPENSES	
7,740	7,740	OCCUPATIO	403,066
7,750			0
7,770	7,770	SPEECH THE	66,190
7,820	7,820	BEAUTICIAN	0
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			0
8,130	8,130	DEPRECIATI	0
8,150			0
9,510	9,510	INTEREST IN	(672)
9,520	9,520	MISC NON-O	0
9,530	4,220		0
	8,100		622,750
	9,702		0
	5,230		0
			(735,004)

Expenses Fixed Assets

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

	G/L	RECAP CENSUS
PP	20,932	20,932
IPA	2,686	2,686
medicare	4,366	4,366
		27,984

Mason City Are Nursing Home
HFS ID# 371168043001
HFS Cost Report - December 31, 2016
Board of Directors

Member	Home City	State
Reverend Jim Sprinkel - President	Mason City	IL
Robert Griffin - Vice President	Mason City	IL
Karen Duckworth	Mason City	IL
Bonnie Dunker	Mason City	IL
Kraig Kruse	Easton	IL
Suzanne Lowers	Easton	IL
Kate Nunn	Easton	IL
Dan Shepherd	San Jose	IL

Rutledge Regency Operations LLC
HFS ID# 465640124001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		Add (Subtract)
Reclassification of Provider Participation Fees		
Provider Participation Fee - $1.50	Line 20, Col 3	(52,155)
Provider Assesment Fee - $6.07	Line 20, Col 3	(143,294)
		(195,449)
Provider Participation Fee	Line 42	195,449
Reclassification of Ancillary Services Cost		
Cost of Drugs Purchased	Line 10(a), Col 2	(742,916)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(22,322)
		(765,238)
Ancillary Service Centers	Line 39	765,238