FOR BHF USE

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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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053371

Facility Name: REGENCY CARE

Address: 2120 West Washington Street (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: David M Underwood **Telephone Number:** 309823-7135
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 1/1/2017 to 12/31/2017 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: 1/1/2017 Ending: 12/31/2017

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 1/4/2017

	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)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	2,369	21,165	2,790	26,324	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3		3	12
13	DD 16 OR LESS					13
14	TOTALS	2,369	21,168	2,790	26,327	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.86%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] 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 99 and days of care provided 2,790

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: 1/1/2017 Ending: 12/31/2017

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	269,226	16,308		285,534		285,534	3,895	289,429			1
2	Food Purchase		226,443		226,443		226,443		226,443			2
3	Housekeeping	69,463	42,188		111,651		111,651	6	111,657			3
4	Laundry	53,591	21,705		75,296		75,296	1	75,297			4
5	Heat and Other Utilities			146,690	146,690		146,690	1,498	148,188			5
6	Maintenance	112,068	56,317	98,800	267,185		267,185	22,854	290,039			6
7	Other (specify):*											7
8	TOTAL General Services	504,348	362,961	245,490	1,112,799		1,112,799	28,254	1,141,053			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	1,805,900	191,839	168,114	2,165,853		2,165,853	(16,464)	2,149,389			10
10a	Therapy		668,513	31,027	699,540	(699,540)						10a
11	Activities	65,945	5,104		71,049		71,049		71,049			11
12	Social Services	38,478		5,371	43,849		43,849		43,849			12
13	CNA Training							1,075	1,075			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,910,323	865,456	246,512	3,022,291	(699,540)	2,322,751	(15,389)	2,307,362			16
	C. General Administration											
17	Administrative	109,546			109,546		109,546		109,546			17
18	Directors Fees											18
19	Professional Services			376,189	376,189		376,189	(352,486)	23,703			19
20	Dues, Fees, Subscriptions & Promotions			284,030	284,030	(197,067)	86,963	(58,124)	28,839			20
21	Clerical & General Office Expenses	388,005	35,427	23,871	447,303		447,303	358,987	806,290			21
22	Employee Benefits & Payroll Taxes			449,301	449,301		449,301	48,539	497,840			22
23	Inservice Training & Education			4,501	4,501		4,501	220	4,721			23
24	Travel and Seminar			3,720	3,720		3,720	1,279	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,405	27,405		27,405	11,710	39,115			26
27	Other (specify):* Lost resident items			33,264	33,264		33,264	(30,600)	2,664			27
28	TOTAL General Administration	497,551	35,427	1,202,281	1,735,259	(197,067)	1,538,192	(20,475)	1,517,717			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,912,222	1,263,844	1,694,283	5,870,349	(896,607)	4,973,742	(7,610)	4,966,132			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: 1/1/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							311,671	311,671			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							236,260	236,260			32
33	Real Estate Taxes							116,504	116,504			33
34	Rent-Facility & Grounds			652,651	652,651		652,651	(646,681)	5,970			34
35	Rent-Equipment & Vehicles			19,841	19,841		19,841	7,627	27,468			35
36	Other (specify):*											36
37	**TOTAL Ownership**			672,492	672,492		672,492	25,381	697,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			747,304	747,304	699,540	1,446,844	(263,363)	1,183,481			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					197,067	197,067		197,067			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			747,304	747,304	896,607	1,643,911	(263,363)	1,380,548			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,912,222	1,263,844	3,114,079	7,290,145		7,290,145	(245,592)	7,044,553			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: 1/1/2017 Ending: 12/31/2017

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	(689)			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	(1,170)			17
18	Fines and Penalties	(31,209)			18
19	Entertainment	(6,864)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,295)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,600)			24
25	Fund Raising, Advertising and Promotional	(35,004)			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)**	$ (109,831)		$	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)	(135,761)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (135,761)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (245,592)		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: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22		(4,295)	19	22
23				23
24		(30,600)	27	24
25		(35,004)	20	25
26				26
27		(31,209)	20	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	(101,108)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,895	0	0	0	0	0	0	0	0	3,895	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	1,498	0	0	0	0	0	0	0	0	1,498	5
6	Maintenance	0	0	22,854	0	0	0	0	0	0	0	0	22,854	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	28,254	0	0	0	0	0	0	0	0	28,254	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	(16,830)	366	0	0	0	0	0	0	0	0	(16,464)	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	1,075	0	0	0	0	0	0	0	0	1,075	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	(16,830)	1,441	0	0	0	0	0	0	0	0	(15,389)	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	(4,295)	(364,715)	16,524	0	0	0	0	0	0	0	0	(352,486)	19
20	Fees, Subscriptions & Promotions	(66,213)	0	8,089	0	0	0	0	0	0	0	0	(58,124)	20
21	Clerical & General Office Expenses	0	0	358,987	0	0	0	0	0	0	0	0	358,987	21
22	Employee Benefits & Payroll Taxes	0	0	48,539	0	0	0	0	0	0	0	0	48,539	22
23	Inservice Training & Education	(1,170)	(278)	1,668	0	0	0	0	0	0	0	0	220	23
24	Travel and Seminar	(6,864)	0	8,143	0	0	0	0	0	0	0	0	1,279	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	11,710	0	0	0	0	0	0	0	0	11,710	26
27	Other (specify):*	(30,600)	0	0	0	0	0	0	0	0	0	0	(30,600)	27
28	**TOTAL General Administration**	(109,142)	(364,993)	453,660	0	0	0	0	0	0	0	0	(20,475)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(109,142)	(381,823)	483,355	0	0	0	0	0	0	0	0	(7,610)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REGENCY CARE # 0053371 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	282,163	0	29,508	0	0	0	0	0	0	0	311,671	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(689)	235,233	0	1,716	0	0	0	0	0	0	0	236,260	32
33	Real Estate Taxes	0	116,504	0	0	0	0	0	0	0	0	0	116,504	33
34	Rent-Facility & Grounds	0	(652,651)	0	5,970	0	0	0	0	0	0	0	(646,681)	34
35	Rent-Equipment & Vehicles	0	0	0	7,627	0	0	0	0	0	0	0	7,627	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(689)	(18,751)	0	44,821	0	0	0	0	0	0	0	25,381	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	(263,363)	0	0	0	0	0	0	0	0	0	(263,363)	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	(263,363)	0	0	0	0	0	0	0	0	0	(263,363)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(109,831)	(663,937)	483,355	44,821	0	0	0	0	0	0	0	(245,592)	45

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. [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)	
1	V	19	Adjustment for Related Organiza	$ 364,715	Heritage Operations Group LLC	0.00%	$	$ (364,715)	1
2	V	34	Adjustment for Related Organization	652,651	Rutledge-Regency Real Estate LLC	0.00%		(652,651)	2
3	V								3
4	V	33	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	116,504	116,504	4
5	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	233,585	233,585	5
6	V	30	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	282,163	282,163	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	10	Adjustment for Related Organization		GreenTree Pharmacy		(16,830)	(16,830)	9
10	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(278)	(278)	10
11	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(263,363)	(263,363)	11
12	V								12
13	V								13
14	Total			$ 1,017,366			$ 353,429	$ * (663,937)	14

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

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	1	Dietary	$	Heritage Operations Group		$	$ 3,895	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					6	17
18	V	4	Laundry					1	18
19	V	5	Heat & Other Utilities					1,498	19
20	V	6	Maintenance					22,854	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					366	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,075	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					16,524	31
32	V	20	Fees, Subscription, Promotions					8,089	32
33	V	21	Clerical & General Office Expenses					358,987	33
34	V	22	Employee Benefits & Payroll Taxes					48,539	34
35	V	23	Inservice Training & Education					1,668	35
36	V	24	Travel and Seminar					8,143	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					11,710	38
39	Total			$			$ 0	$ * 483,355	39

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

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	27	Other	$	Heritage Operations Group		$	$ 0	15
16	V	30	Depreciation					29,508	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					1,716	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,970	20
21	V	35	Rent-Equipment & Vehicles					7,627	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	$ * 44,821	39

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

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 2/31/2017

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	2,578	26	$ 101,433	$ 109,431	99	$ 3,895	1
2	2	Food Purchase	Beds	2,578	26	0	0	99	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	99	6	3
4	4	Laundry	Beds	2,578	26	16	0	99	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	99	1,498	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	99	22,854	6
7	7	Other	Beds	2,578	26	0	0	99	0	7
8	9	Medical Director	Beds	2,578	26	0	0	99	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	99	366	9
10	11	Activities	Beds	2,578	26	0	0	99	0	10
11	12	Social Service	Beds	2,578	26	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	99	1,075	12
13	14	Program Transportation	Beds	2,578	26	0	0	99	0	13
14	15	Other	Beds	2,578	26	0	0	99	0	14
15	17	Administrative	Beds	2,578	26	0	0	99	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	99	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	99	16,524	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	99	8,089	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	99	358,987	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,578	26	1,263,974	0	99	48,539	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	99	1,668	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	99	8,143	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	99	11,710	24
25	TOTALS					$ 12,586,763	$ 9,050,304		$ 483,355	25

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	27	Other	Beds	2,578	26	$	$	99	$	1
2	30	Depreciation	Beds	2,578	26	768,393		99	29,508	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26			99		3
4	32	Interest	Beds	2,578	26	44,696		99	1,716	4
5	33	Real Estate Taxes	Beds	2,578	26			99		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453		99	5,970	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602		99	7,627	7
8	36	Other	Beds	2,578	26			99		8
9	38	Medically Nec Transportation	Beds	2,578	26			99		9
10	39	Ancillary Service Centers	Beds	2,578	26			99		10
11	40	Barber and Beauty Shops	Beds	2,578	26			99		11
12	41	Coffee and Gift Shops	Beds	2,578	26			99		12
13	42	Other	Beds	2,578	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					$ 1,167,144	$		$ 44,821	25

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lancaster-Pollard		x	Mortgage			$	$			$ 233,585	1
2				Loan Fee Amortization							1,648	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 235,233	9
	B. Non-Facility Related*											
10	Interest Income										(689)	10
11												11
12	Allocated Corporate										1,716	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,027	14
15	TOTALS (line 9+line14)						$	$			$ 236,260	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 30,021 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: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	$	116,504	2
3. Under or (over) accrual (line 2 minus line 1).	$	116,504	3
4. Real Estate Tax accrual used for 2017 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.	$	116,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014	113,647	10
2015	115,376	11
2016	116,504	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REGENCY CARE COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 53371

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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14320101024		$ 116,504.46	$ 116,504.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,504.46	$ 116,504.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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				2015	40,016						9
10	Cabling for new IT systems			2015	28,951						10
11	Phone system installation			2015	4,192						11
12	Install (2) water heaters			2015	4,961						12
13	Install new freezer			2015	3,284						13
14	Install (2) new temering replacement valves			2015	9,074						14
15	Rebuild roof where splits occurred										15
16				2016	18,700						16
17	Install new water heater			2016	63,430						17
18	Install tile flooring - Various corridors, nurses stations and specific resident										18
19	rooms in the East, West and Center wings (Wings map attached)										19
20											20
21	New air compressor installed in fire sprinkle system			2017	2,740						21
22	Wall and floor rebuild - damaged by water			2017	2,615						22
23	Purchased water heater			2017	7,490						23
24	Replaced fire sprinkler piping - canopy			2017	6,928						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33						29,508		29,508			33
34						215,871		215,871			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: 1/1/2017 Ending: 12/31/2017

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)		$ 7,658,682	$ 245,379		$ 245,379	$	$	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: 1/1/2017 Ending: 12/31/2017

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	$ 462,244	$ 57,737	$ 57,737	$		$	71
72	Current Year Purchases	3,617						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 465,861	$ 57,737	$ 57,737	$		$	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	$ 8,555	$ 8,555	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 59,887	$ 8,555	$ 8,555	$		$	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)	$ 8,804,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 311,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 311,671	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: 1/1/2017 Ending: 12/31/2017

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:				$ 652,651	27		3
4	Additions							4
5								5
6								6
7	TOTAL				$ 652,651 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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 [ ] 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: $ 19,841 Description: Televisions and copiers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.

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	$		$ 365,640	$		$ 365,640	1
2	Licensed Speech and Language Development Therapist		hrs			55,998			55,998	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			325,666	0		325,666	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				668,513		668,513	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					31,027			31,027	13
14	TOTAL			$		$ 778,331	$ 668,513		$ 1,446,844	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:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 1,488,329	$	1
2	Cash-Patient Deposits	6,157		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	543,169		3
4	Supply Inventory (priced at FIFO)	52,640		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,833		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	340,634		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,436,762	$	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)**	$ 2,436,762	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 515,785	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,157		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	23,363		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 545,305	$	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)**	$ 545,305	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,891,457	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,436,762	$	48

***(See instructions.)**

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,713,155	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,713,155	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	178,302	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)**	$ 178,302	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)**	$ 1,891,457	24 *

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

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 6,153,721	1
2	Discounts and Allowances for all Levels	(2,886,534)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,267,187	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,869,113	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,869,113	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	1,345,713	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(14,255)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,331,458	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	689	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 689	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)**	$ 7,468,447	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,112,799	31
32	Health Care	3,022,291	32
33	General Administration	1,735,259	33
	B. Capital Expense		
34	Ownership	672,492	34
	C. Ancillary Expense		
35	Special Cost Centers	747,304	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)***	$ 7,290,145	40
41	**Income before Income Taxes (line 30 minus line 40)****	178,302	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 178,302	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: 1/1/2017 Ending: 12/31/2017

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	1,718	1,809	$ 67,737	$ 37.44	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,202	8,634	277,916	32.19	3
4	Licensed Practical Nurses	19,271	20,285	497,872	24.54	4
5	CNAs & Orderlies	60,042	63,202	896,978	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,114	4,331	65,397	15.10	8
9	Activity Director					9
10	Activity Assistants	4,826	5,080	65,945	12.98	10
11	Social Service Workers	1,515	1,595	38,478	24.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,113	21,171	269,226	12.72	15
16	Dishwashers					16
17	Maintenance Workers	7,945	8,364	112,068	13.40	17
18	Housekeepers	6,869	7,231	69,463	9.61	18
19	Laundry	5,230	5,505	53,591	9.73	19
20	Administrator	1,756	1,848	109,546	59.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,110	18,011	388,005	21.54	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)	158,711	167,066	$ 2,912,222 *	$ 17.43	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		4,345		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		5,371		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 53,796		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 12,100		50
51	Licensed Practical Nurses		100,135		51
52	Certified Nurse Assistants/Aides		49,318		52
53	TOTAL (lines 50 - 52)		$ 161,553		53

Facility Name & ID Number REGENCY CARE # 0053371 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Twardowski			$ 109,546
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,546

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	$ 365,644
Sulaski & Webb	Audit & Tax	6,250
Legal adj to Zero		4,295
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 376,189

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,575
Unemployment Compensation Insurance	23,141
FICA Taxes	222,785
Employee Health Insurance	94,499
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	22,301
Central Office Allocation	48,539
TOTAL (agree to Schedule V, line 22, col.8)	$ 497,840

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	8,191
Health Care Worker Background Check	
(Indicate # of checks performed)	2,456
Patient Background Checks	
PR	17,695
Dues & Subscriptions	7,872
License & Fees	2,978
Central Office Allocation	8,089
Less: Public Relations Expense	(17,695)
Non-allowable advertising	(747)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,839

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,152
	0
Seminar Expense	1,568
	1,279
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: 1/1/2017 Ending: 12/31/2017

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 Yrs**

(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. $ **197,067**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,057**

(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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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

Rutledge Regency Operations
HFS ID# 53371
HFS Cost Report - December 31, 2017
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	668,513
Purchased Hospital Services		909
Purchased Laboratory Services		19,254
Purchased Radiology Services		10,864
Amount Reclassified to Line 39	$	699,540

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	54,203
Provider Assessment Fee - $6.70		142,864
Amount Reclassified to Line 42		197,067