

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>53371</u></p> <p>Facility Name: <u>Rutledge - Regency Operations LLC</u></p> <p>Address: <u>2120 West Washington Street</u> <u>Springfield</u> <u>62702</u> Number City Zip Code</p> <p>County: <u>Sangamon</u></p> <p>Telephone Number: <u>(217)793-4880</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>Feb 2015</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>David M Underwood</u> Telephone Number: <u>309823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David M Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>EVP/CFO</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td>Fax # () _____</td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>David M Underwood</u>			(Title) <u>EVP/CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																												
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Paid Preparer	(Signed) _____	(Date) _____																																												
	(Print Name and Title) _____																																													
	(Firm Name & Address) _____																																													
	(Telephone) () _____	Fax # () _____																																												

Facility Name & ID Number Rutledge - Regency Operations LLC

53371 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,490	18,836	3,213	24,539	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,490	18,836	3,213	24,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.91%

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

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

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 Date 2/1/2015 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 3,213

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Rutledge - Regency Operations LLC # 53371 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	248,940	16,026	6,710	271,676		271,676	3,996	275,672		1
2	Food Purchase		202,552		202,552		202,552	52	202,604		2
3	Housekeeping	86,563	37,338		123,901		123,901		123,901		3
4	Laundry	60,664	22,824		83,488		83,488	4	83,492		4
5	Heat and Other Utilities			162,415	162,415		162,415	1,451	163,866		5
6	Maintenance	104,387	61,430	111,949	277,766		277,766	21,930	299,696		6
7	Other (specify):*										7
8	TOTAL General Services	500,554	340,170	281,074	1,121,798		1,121,798	27,433	1,149,231		8
	B. Health Care and Programs										
9	Medical Director			42,000	42,000		42,000		42,000		9
10	Nursing and Medical Records	2,001,908	166,482	77,773	2,246,163		2,246,163	(19,065)	2,227,098		10
10a	Therapy		319,889	36,181	356,070	(356,070)					10a
11	Activities	59,665	3,228		62,893		62,893		62,893		11
12	Social Services	32,873		5,040	37,913		37,913		37,913		12
13	CNA Training							1,148	1,148		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,094,446	489,599	160,994	2,745,039	(356,070)	2,388,969	(17,917)	2,371,052		16
	C. General Administration										
17	Administrative	99,526			99,526		99,526		99,526		17
18	Directors Fees										18
19	Professional Services			348,732	348,732		348,732	(323,664)	25,068		19
20	Dues, Fees, Subscriptions & Promotions			254,374	254,374	(191,355)	63,019	(27,588)	35,431		20
21	Clerical & General Office Expenses	430,606	23,731	21,946	476,283		476,283	351,018	827,301		21
22	Employee Benefits & Payroll Taxes			477,930	477,930		477,930	45,784	523,714		22
23	Inservice Training & Education			4,730	4,730		4,730	269	4,999		23
24	Travel and Seminar			4,582	4,582		4,582	417	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,507	30,507		30,507	24,690	55,197		26
27	Other (specify):* Lost resident items			1,029	1,029		1,029	(100)	929		27
28	TOTAL General Administration	530,132	23,731	1,143,830	1,697,693	(191,355)	1,506,338	70,826	1,577,164		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,125,132	853,500	1,585,898	5,564,530	(547,425)	5,017,105	80,342	5,097,447		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							311,722	311,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							226,740	226,740			32
33	Real Estate Taxes							118,838	118,838			33
34	Rent-Facility & Grounds			633,462	633,462		633,462	(627,389)	6,073			34
35	Rent-Equipment & Vehicles			21,569	21,569		21,569	6,148	27,717			35
36	Other (specify):*											36
37	TOTAL Ownership			655,031	655,031		655,031	36,059	691,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			738,035	738,035	356,070	1,094,105	45,729	1,139,834			39
40	Barber and Beauty Shops			14	14		14		14			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					191,355	191,355		191,355			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			738,049	738,049	547,425	1,285,474	45,729	1,331,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,125,132	853,500	2,978,978	6,957,610		6,957,610	162,130	7,119,740			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 Rutledge - Regency Operations LLC

53371

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(2,405)			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	(1,091)			17
18	Fines and Penalties				18
19	Entertainment	(6,948)			19
20	Contributions	(100)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,365)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,148)			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)	\$ (52,057)		\$	30

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	2	
		Amount	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)	214,187		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 214,187		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 162,130		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

Rutledge - Regency Operations LLC

ID# 53371

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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		0	30	22
23		(4,365)	19	23
24		0	27	24
25		(37,148)	20	25
26		(6,948)	24	26
27		(100)	27	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,561)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rutledge - Regency Operations LLC# 53371

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	3,996	0	0	0	0	0	0	0	0	3,996	1
2	Food Purchase	0	0	52	0	0	0	0	0	0	0	0	52	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,451	0	0	0	0	0	0	0	0	1,451	5
6	Maintenance	0	0	21,930	0	0	0	0	0	0	0	0	21,930	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,433	0	0	0	0	0	0	0	0	27,433	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	(19,704)	639	0	0	0	0	0	0	0	0	(19,065)	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	1,148	0	0	0	0	0	0	0	0	1,148	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	(19,704)	1,787	0	0	0	0	0	0	0	0	(17,917)	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	(4,365)	(336,239)	16,940	0	0	0	0	0	0	0	0	(323,664)	19
20	Fees, Subscriptions & Promotions	(37,148)	0	9,560	0	0	0	0	0	0	0	0	(27,588)	20
21	Clerical & General Office Expenses	0	0	351,018	0	0	0	0	0	0	0	0	351,018	21
22	Employee Benefits & Payroll Taxes	0	0	45,784	0	0	0	0	0	0	0	0	45,784	22
23	Inservice Training & Education	(1,091)	(360)	1,720	0	0	0	0	0	0	0	0	269	23
24	Travel and Seminar	(6,948)	0	7,365	0	0	0	0	0	0	0	0	417	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	24,690	0	0	0	0	0	0	0	0	24,690	26
27	Other (specify):*	(100)	0	0	0	0	0	0	0	0	0	0	(100)	27
28	TOTAL General Administration	(49,652)	(336,599)	457,077	0	0	0	0	0	0	0	0	70,826	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,652)	(356,303)	486,297	0	0	0	0	0	0	0	0	80,342	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rutledge - Regency Operations LLC# 53371

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	283,779	0	27,943	0	0	0	0	0	0	0	311,722	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,405)	229,145	0	0	0	0	0	0	0	0	0	226,740	32
33	Real Estate Taxes	0	118,838	0	0	0	0	0	0	0	0	0	118,838	33
34	Rent-Facility & Grounds	0	(633,462)	0	6,073	0	0	0	0	0	0	0	(627,389)	34
35	Rent-Equipment & Vehicles	0	0	0	6,148	0	0	0	0	0	0	0	6,148	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,405)	(1,700)	0	40,164	0	0	0	0	0	0	0	36,059	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	45,729	0	0	0	0	0	0	0	0	0	45,729	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	45,729	0	0	0	0	0	0	0	0	0	45,729	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(52,057)	(312,274)	486,297	40,164	0	0	0	0	0	0	0	162,130	45

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		Heritage Operations G	Bloomington	Mgmt. Services
Rutledge - Regency Holdings LLC	1%			Green Tree Pharmacy	Minonk	Pharmacy
				Rutledge-Regency Rea	Springfield	Real Estate Holding

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 Adjustment for Related Organization	\$	GreenTree Pharmacy		\$ (19,704)	\$ (19,704)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(360)	(360)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		45,729	45,729	3
4	V	19 Adjustment for Related Organization	336,239	Heritage Operations Group, LLC			(336,239)	4
5	V							5
6	V	34 Adjustment for Related Organization	633,462	Rutledge-Regency Real Estate LLC			(633,462)	6
7	V	33 Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		118,838	118,838	7
8	V	32 Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		227,497	227,497	8
9	V	30 Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		283,779	283,779	9
10	V	32 Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		1,648	1,648	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 969,701			\$ 657,427	\$ * (312,274)	14

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

Facility Name & ID Number

Rutledge - Regency Operations LLC

53371

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Operations Group		\$	3,996	15
16	V	2 Food Purchase		Heritage Operations Group			52	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			4	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			1,451	19
20	V	6 Maintenance		Heritage Operations Group			21,930	20
21	V	7 Other		Heritage Operations Group			0	21
22	V	9 Medical Director		Heritage Operations Group			0	22
23	V	10 Nursing & Medical Records		Heritage Operations Group			639	23
24	V	11 Activities		Heritage Operations Group			0	24
25	V	12 Social Service		Heritage Operations Group			0	25
26	V	13 Nurse Aide Training		Heritage Operations Group			1,148	26
27	V	14 Program Transportation		Heritage Operations Group			0	27
28	V	15 Other		Heritage Operations Group			0	28
29	V	17 Administrative		Heritage Operations Group			0	29
30	V	18 Directors Fees		Heritage Operations Group			0	30
31	V	19 Professional Services		Heritage Operations Group			16,940	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			9,560	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			351,018	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			45,784	34
35	V	23 Inservice Training & Education		Heritage Operations Group			1,720	35
36	V	24 Travel and Seminar		Heritage Operations Group			7,365	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			24,690	38
39	Total		\$			\$	0	\$ * 486,297 39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Operations Group		\$	0	15
16	V	30 Depreciation		Heritage Operations Group			27,943	16
17	V	31 Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32 Interest		Heritage Operations Group			0	18
19	V	33 Real Estate Taxes		Heritage Operations Group			0	19
20	V	34 Rent-Facility & Grounds		Heritage Operations Group			6,073	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			6,148	21
22	V	36 Other		Heritage Operations Group			0	22
23	V	38 Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39 Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40 Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41 Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42 Other		Heritage Operations Group			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	\$ * 40,164

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

Facility Name & ID Number Rutledge - Regency Operations LLC # 53371 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	<u>Rutledge Joint Ventures LLC</u>			<u>99%</u>	<u>0</u>				\$ <u>0</u>	1
2	<u>Rutledge - Regency Holdings LLC</u>			<u>1%</u>	<u>0</u>				\$ <u>0</u>	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 Rutledge - Regency Operations LLC # 53371 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,578	26	\$ 104,045	\$ 103,180	99	\$ 3,996	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	99	52	2
3	3	Housekeeping	Beds	2,578	26	0	0	99	0	3
4	4	Laundry	Beds	2,578	26	111	0	99	4	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	99	1,451	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	99	21,930	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	16,650	12,036	99	639	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	29,896	28,423	99	1,148	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	441,112	0	99	16,940	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	99	9,560	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	99	351,018	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	99	45,784	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	99	1,720	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	99	7,365	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	99	24,690	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 486,297	25

Facility Name & ID Number Rutledge - Regency Operations LLC # 53371 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,578	26	\$	\$	99	\$	1
2	30	Depreciation	Beds	2,578	26	727,658		99	27,943	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26			99		3
4	32	Interest	Beds	2,578	26			99		4
5	33	Real Estate Taxes	Beds	2,578	26			99		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134		99	6,073	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109		99	6,148	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					\$ 1,045,901	\$		\$ 40,164	25

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			\$	\$		\$ 227,497	1									
2			x	Loan Fee Amortization						1,648	2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 229,145	9									
B. Non-Facility Related*																				
10	Interest Income									(2,405)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (2,405)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 226,740	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,238 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 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.)	\$	118,838	2
3. Under or (over) accrual (line 2 minus line 1).	\$	118,838	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	118,838	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013		8
	2014	113,647	9
	2015	115,376	10
	2016	116,504	11
	2017		12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rutledge - Regency Operations LLC 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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14320101024</u>	_____	\$ <u>118,838.36</u>	\$ <u>118,838.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>118,838.36</u></u>	\$ <u><u>118,838.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

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 (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 (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>2015</u>	<u>\$ 620,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 620,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99	2015		\$ 7,466,301	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Cabling for new IT systems		2015	40,016					
10	Phone system installation		2015	28,951					
11	Install (2) water heaters		2015	4,192					
12	Install new freezer		2015	4,961					
13	Install (2) new tempering replacement valves		2015	3,284					
14	Rebuild roof where splits occurred		2015	9,074					
15									
16	Install new water heater		2016	18,700					
17	Install tile flooring - Various corridors, nurses stations and specific resident rooms in the East, West and Center wings (Wings map attached)		2016	63,430					
18									
19									
20	New air compressor installed in fire sprinkle system		2017	2,740					
21	Wall and floor rebuild - damaged by water		2017	2,615					
22	Purchased water heater		2017	7,490					
23	Replaced fire sprinkler piping - canopy		2017	6,928					
24									
25	Install rooftop 5-ton RTU unit		2018	18,970					
26									
27									
28									
29									
30									
31									
32									
33									
34	C/O Allocation				27,943		27,943		
35	Book Depreciation				216,503		216,503		
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 Rutledge - Regency Operations LLC

53371

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)	\$ 7,677,652	\$ 244,446		\$ 244,446	\$	\$	70

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

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	\$ 465,861	\$ 58,721	\$ 58,721	\$		\$	71
72	Current Year Purchases	5,531						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 471,392	\$ 58,721	\$ 58,721	\$		\$	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)	\$ 8,828,931	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 311,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,722	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.

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. 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:				\$ <u>633,462</u>	<u>27</u>		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>633,462</u>			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.	<u>/2019</u>	\$ <u>633,462</u>
13.	<u>/2020</u>	\$ <u>633,462</u>
14.	<u>/2021</u>	\$ <u>633,462</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 21,569 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

- (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.

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	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	382,606	\$		\$	382,606					1
2	Licensed Speech and Language Development Therapist		hrs				34,371									2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs				321,058		0							4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts							319,889						9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):									36,181						13
14	TOTAL			\$		\$	774,216	\$	319,889	\$	1,094,105					14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rutledge - Regency Operations LLC

53371

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(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	\$ 1,282,090	\$	1
2	Cash-Patient Deposits	5,296		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	378,105		3
4	Supply Inventory (priced at <u>FIFO</u>)	49,610		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,824		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	535,691		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,253,616	\$	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)	\$ 2,253,616	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 440,106	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,296		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	<u>Bed Tax</u>	10,034		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 455,436	\$	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)	\$ 455,436	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,798,180	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,253,616	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,891,456	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,891,456	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,276)	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)	\$ (93,276)	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)	\$ 1,798,180	24 *

* This must agree with page 17, line 47.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,173,610	1
2	Discounts and Allowances for all Levels	(2,677,413)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,496,197	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,748,228	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,748,228	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	616,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,022	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 617,504	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,405	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,405	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)	\$ 6,864,334	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,121,798	31
32	Health Care	2,745,039	32
33	General Administration	1,697,693	33
B. Capital Expense			
34	Ownership	655,031	34
C. Ancillary Expense			
35	Special Cost Centers	738,049	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)*	\$ 6,957,610	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,276)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,276)	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 **Rutledge - Regency Operations LLC**

53371

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,684	1,792	\$ 73,413	\$ 40.97	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,631	9,182	323,199	35.20	3
4	Licensed Practical Nurses	19,207	20,433	549,081	26.87	4
5	CNAs & Orderlies	58,716	62,464	1,016,852	16.28	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,964	2,089	39,363	18.84	8
9	Activity Director					9
10	Activity Assistants	4,260	4,532	59,665	13.17	10
11	Social Service Workers	1,280	1,362	32,873	24.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,017	19,167	248,940	12.99	15
16	Dishwashers					16
17	Maintenance Workers	6,615	7,037	104,387	14.83	17
18	Housekeepers	7,939	8,446	86,563	10.25	18
19	Laundry	5,417	5,763	60,664	10.53	19
20	Administrator	1,955	2,080	99,526	47.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,692	18,821	430,606	22.88	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)	153,377	163,168	\$ 3,125,132 *	\$ 19.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 6,710		35
36	Medical Director		42,000		36
37	Medical Records Consultant		1,600		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,614		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		5,040		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 59,964		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 605		50
51	Licensed Practical Nurses		52,980		51
52	Certified Nurse Assistants/Aides		17,381		52
53	TOTAL (lines 50 - 52)		\$ 70,966		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shana Lister			\$ 99,526	Workers' Compensation Insurance	\$ 64,569	IDPH License Fee	\$	
				Unemployment Compensation Insurance	16,141	Advertising: Employee Recruitment	4,993	
				FICA Taxes	239,073	Health Care Worker Background Check (Indicate # of checks performed)	2,703	
				Employee Health Insurance	135,090	Patient Background Checks		
				Employee Meals		PR	13,800	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,839	
				Other Benefits	23,057	License & Fees	5,336	
				Central Office Allocation	45,784	Central Office Allocation	9,560	
						Less: Public Relations Expense	(13,800)	
						Non-allowable advertising	(0)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,526	TOTAL (agree to Schedule V, line 22, col.8)	\$ 523,714	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,431	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ 0			\$	Out-of-State Travel	\$
							In-State Travel	
								3,038
								0
							Seminar Expense	1,544
								417
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Operations Group	Management		\$ 337,867					
May Cocagne & King	2017 Audit		6,500					
Legal adj to Zero			4,365					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 348,732					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rutledge - Regency Operations LLC

53371

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

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. NA
- (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. \$ 191,355
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,840
- (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: May Cocagne & King
- (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

Table with columns: Account, Description, GL, Cost, and Amount. It lists numerous accounts such as ACCOUNT RECEIVABLE, PREPAID EXPENSE, and various equity accounts, each with associated amounts and GL codes.

GRAND TOTALS 91,271 188,237 82,257
FACILITY NAME 0
FACILITY ID 0

BALANCE SHEET TOTAL 0
GL HEAD PENDING

Table with columns: Account, Description, GL, Cost, and Amount. It continues the list of accounts from the previous section, including FURNITURE, EQUIPMENT, and various liability and equity accounts, with associated amounts and GL codes.

GRAND TOTALS 91,271 188,237 82,257
FACILITY NAME 0
FACILITY ID 0

BALANCE SHEET TOTAL 0
GL HEAD PENDING

Rutledge Regency Operations
IDPH ID# 53371
HFS Cost Report - December 31, 2018
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 319,889
Purchased Hospital Services	10,788
Purchased Laboratory Services	17,804
Purchased Radiology Services	7,589
Amount Reclassified to Line 39	<u>\$ 356,070</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (54,203)
Provider Assesment Fee - \$6.07	<u>(137,152)</u>
	<u>(191,355)</u>
Provider Participation Fee - Line 42	<u>191,355</u>