		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0053371

Facility Name: Regency Care

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

County: Sangamon

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

HFS ID Number:

Date of Initial License for Current Owners: Feb 2015

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		xx	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** (309)8237135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) 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: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	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	99	Skilled (SNF)	99	36,234	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	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,065	14,020	3,538	20,623	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,065	14,020	3,538	20,623	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.92%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [xx]

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

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 [xx] Date Feb 2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 99 and days of care provided 3,538

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] 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: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	248,097	19,224	6,710	274,031		274,031	4,830	278,861			1
2	Food Purchase		184,639		184,639		184,639	(17)	184,622			2
3	Housekeeping	111,258	43,350		154,608		154,608	6,439	161,047			3
4	Laundry	45,660	23,455		69,115		69,115	460	69,575			4
5	Heat and Other Utilities			128,576	128,576		128,576	1,533	130,109			5
6	Maintenance	124,321	77,087	134,259	335,667		335,667	18,793	354,460			6
7	Other (specify):*											7
8	**TOTAL General Services**	529,336	347,755	269,545	1,146,636		1,146,636	32,038	1,178,674			8
	B. Health Care and Programs											
9	Medical Director			66,000	66,000		66,000		66,000			9
10	Nursing and Medical Records	1,847,506	200,613	261,835	2,309,954	(4,886)	2,305,068	12,837	2,317,905			10
10a	Therapy		254,845	23,098	277,943	(273,057)	4,886		4,886			10a
11	Activities	84,893	11,236		96,129		96,129	5	96,134			11
12	Social Services	39,733	2,402		42,135		42,135	138	42,273			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,972,132	469,096	350,933	2,792,161	(277,943)	2,514,218	12,980	2,527,198			16
	C. General Administration											
17	Administrative	87,786			87,786		87,786		87,786			17
18	Directors Fees											18
19	Professional Services			301,328	301,328		301,328	(274,125)	27,203			19
20	Dues, Fees, Subscriptions & Promotions			213,111	213,111	(167,544)	45,567	(23,677)	21,890			20
21	Clerical & General Office Expenses	446,904	33,220	13,696	493,820		493,820	412,100	905,920			21
22	Employee Benefits & Payroll Taxes			484,879	484,879		484,879	41,501	526,380			22
23	Inservice Training & Education			180	180		180	1,125	1,305			23
24	Travel and Seminar			3,152	3,152		3,152	1,847	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,759	47,759		47,759	68,750	116,509			26
27	Other (specify):* **Lost resident items**			23,130	23,130		23,130	(22,521)	609			27
28	**TOTAL General Administration**	534,690	33,220	1,087,235	1,655,145	(167,544)	1,487,601	205,000	1,692,601			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,036,158	850,071	1,707,713	5,593,942	(445,487)	5,148,455	250,018	5,398,473			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: 1/1/2020 Ending: 12/31/2020

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							319,002	319,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							218,842	218,842			32
33	Real Estate Taxes							111,487	111,487			33
34	Rent-Facility & Grounds			640,110	640,110		640,110	(632,958)	7,152			34
35	Rent-Equipment & Vehicles			56,257	56,257		56,257	12,662	68,919			35
36	Other (specify):*											36
37	**TOTAL Ownership**			696,367	696,367		696,367	29,035	725,402			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			22,939	22,939		22,939		22,939			38
39	Ancillary Service Centers			517,419	517,419	277,943	795,362	80,145	875,507			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					167,544	167,544		167,544			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			540,358	540,358	445,487	985,845	80,145	1,065,990			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,036,158	850,071	2,944,438	6,830,667		6,830,667	359,198	7,189,865			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: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(97)			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	(2,970)			17
18	Fines and Penalties	(1,521)			18
19	Entertainment	(3,307)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,982)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,000)			24
25	Fund Raising, Advertising and Promotional	(21,658)			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)**	$ (53,535)		$	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)	412,733		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 412,733		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 359,198		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: 1/1/2020

Ending: 12/31/2020

	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		(2,982)	19	11
12		(97)	32	12
13		(21,000)	27	13
14		(21,658)	20	14
15		(2,970)	20	15
16		(1,521)	27	16
17		(3,307)	24	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(53,535)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	4,830	0	0	0	0	0	0	0	0	4,830	1
2	Food Purchase	0	0	(17)	0	0	0	0	0	0	0	0	(17)	2
3	Housekeeping	0	0	6,439	0	0	0	0	0	0	0	0	6,439	3
4	Laundry	0	0	460	0	0	0	0	0	0	0	0	460	4
5	Heat and Other Utilities	0	0	1,533	0	0	0	0	0	0	0	0	1,533	5
6	Maintenance	0	0	18,793	0	0	0	0	0	0	0	0	18,793	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	32,038	0	0	0	0	0	0	0	0	32,038	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	(12,176)	25,013	0	0	0	0	0	0	0	0	12,837	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	138	0	0	0	0	0	0	0	0	138	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	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	(12,176)	25,156	0	0	0	0	0	0	0	0	12,980	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	(2,982)	(287,539)	16,396	0	0	0	0	0	0	0	0	(274,125)	19
20	Fees, Subscriptions & Promotions	(24,628)	0	951	0	0	0	0	0	0	0	0	(23,677)	20
21	Clerical & General Office Expenses	0	0	412,100	0	0	0	0	0	0	0	0	412,100	21
22	Employee Benefits & Payroll Taxes	0	0	41,501	0	0	0	0	0	0	0	0	41,501	22
23	Inservice Training & Education	0	(180)	1,305	0	0	0	0	0	0	0	0	1,125	23
24	Travel and Seminar	(3,307)	0	5,154	0	0	0	0	0	0	0	0	1,847	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	68,750	0	0	0	0	0	0	0	0	68,750	26
27	Other (specify):*	(22,521)	0	0	0	0	0	0	0	0	0	0	(22,521)	27
28	TOTAL General Administration	(53,438)	(287,719)	546,157	0	0	0	0	0	0	0	0	205,000	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,438)	(299,895)	603,351	0	0	0	0	0	0	0	0	250,018	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Care **#** 0053371 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	295,772	0	23,230	0	0	0	0	0	0	0	319,002	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97)	216,332	0	2,607	0	0	0	0	0	0	0	218,842	32
33	Real Estate Taxes	0	111,487	0	0	0	0	0	0	0	0	0	111,487	33
34	Rent-Facility & Grounds	0	(640,110)	0	7,152	0	0	0	0	0	0	0	(632,958)	34
35	Rent-Equipment & Vehicles	0	0	0	12,662	0	0	0	0	0	0	0	12,662	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(97)	(16,519)	0	45,651	0	0	0	0	0	0	0	29,035	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	79,959	0	186	0	0	0	0	0	0	0	80,145	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	79,959	0	186	0	0	0	0	0	0	0	80,145	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,535)	(236,455)	603,351	45,837	0	0	0	0	0	0	0	359,198	45

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rutledge Joint Ventures LLC	99	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
Rutledge - Regency Holdings LLC	1			Green Tree Pharmacy	Minonk	Pharmacy
				Rutledge-Regency Rea	Bloomington	Propert rental

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. [xx] 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	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (12,176)	$ (12,176)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(180)	(180)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		79,959	79,959	3
4	V	19	Adjustment for Related Organization	287,539	Heritage Operations Group, LLC			(287,539)	4
5	V								5
6	V	34	Adjustment for Related Organization	640,110	Rutledge-Regency Real Estate LLC			(640,110)	6
7	V	33	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		111,487	111,487	7
8	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		214,684	214,684	8
9	V	30	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC		295,772	295,772	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			$ 927,649			$ 691,194	$ * (236,455)	14

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] 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		$ 4,830	$ 4,830	15
16	V	2	Food Purchase		Heritage Operations Group		(17)	(17)	16
17	V	3	Housekeeping		Heritage Operations Group		6,439	6,439	17
18	V	4	Laundry		Heritage Operations Group		460	460	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,533	1,533	19
20	V	6	Maintenance		Heritage Operations Group		18,793	18,793	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		25,013	25,013	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		138	138	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0		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		16,396	16,396	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		951	951	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		412,100	412,100	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		41,501	41,501	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,305	1,305	35
36	V	24	Travel and Seminar		Heritage Operations Group		5,154	5,154	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		68,750	68,750	38
39	Total			$			$ 603,351	$ * 603,351	39

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] 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		Heritage Operations Group		23,230	23,230	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group		0		17
18	V	32	Interest		Heritage Operations Group		2,607	2,607	18
19	V	33	Real Estate Taxes		Heritage Operations Group		0		19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group		7,152	7,152	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group		12,662	12,662	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		186	186	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			$			$ 45,837	$ * 45,837	39

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	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	Rutledge Joint Ventures LLC			99.00	0	0			$ 0		1
2	Rutledge - Regency Holdings LLC			1.00	0	0			0		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: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Heritage Operations Group
Street Address: 115 W Jefferson Street
City / State / Zip Code: Bloomington, IL 61701
Phone Number: (309 828-4361
Fax Number: (309 829-5477

	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	2,493	25	$ 121,634	$ 121,338	99	$ 4,830	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	99	(17)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	99	6,439	3
4	4	Laundry	Beds	2,493	25	11,591	0	99	460	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	99	1,533	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	99	18,793	6
7	7	Other	Beds	2,493	25	0	0	99	0	7
8	9	Medical Director	Beds	2,493	25	0	0	99	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	99	25,013	9
10	11	Activities	Beds	2,493	25	129	0	99	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	99	138	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	99	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	99	0	13
14	15	Other	Beds	2,493	25	0	0	99	0	14
15	17	Administrative	Beds	2,493	25	0	0	99	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	99	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	99	16,396	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	99	951	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	99	412,100	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	99	41,501	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	99	1,305	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	99	5,154	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	99	68,750	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 603,351	25

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Heritage Operations Group
Street Address: 115 W Jefferson Street
City / State / Zip Code: Bloomington, IL 61701
Phone Number: (309 828-4361
Fax Number: (309 829-5477

	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	2,493	25	$	$	99	$	1
2	30	Depreciation	Beds	2,493	25	584,981		99	23,230	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			99		3
4	32	Interest	Beds	2,493	25	65,658		99	2,607	4
5	33	Real Estate Taxes	Beds	2,493	25			99		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		99	7,152	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		99	12,662	7
8	36	Other	Beds	2,493	25			99		8
9	38	Medically Nec Transportation	Beds	2,493	25			99		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		99	186	10
11	40	Barber and Beauty Shops	Beds	2,493	25			99		11
12	41	Coffee and Gift Shops	Beds	2,493	25			99		12
13	42	Other	Beds	2,493	25			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					$ 1,154,273	$		$ 45,837	25

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Lument (fka Lancaster Pollard)		xx	Mortgage			$	$			$ 214,684	1
2			xx	Loan Fee Amortization							1,648	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 216,332	9
	B. Non-Facility Related*											
10	Interest Income										(97)	10
11												11
12	Allocated Corporate										2,607	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,510	14
15	TOTALS (line 9+line14)						$	$			$ 218,842	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 27,591 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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)	$	111,487	2
3. Under or (over) accrual (line 2 minus line 1).	$	111,487	3
4. Real Estate Tax accrual used for 2020 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.	$	111,487	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	115,376	8
2016	116,504	9
2017	118,838	10
2018	121,352	11
2019	111,487	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Care COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0053371

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14320101024		$ 111,487.38	$ 111,487.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 111,487.38	$ 111,487.00

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 xx NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 [xx] (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 [xx] (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 [xx] 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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2015		$ 7,466,301	$		$	$	$	4
5					180,000						5
6											6
7											7
8											8
	Improvement Type**										
9	Cabling for new IT systems			2015	40,016						9
10	Phone system installation			2015	28,951						10
11	Install (2) water heaters			2015	4,192						11
12	Install new freezer			2015	4,961						12
13	Install (2) new temering replacement valves			2015	3,284						13
14	Rebuild roof where splits occurred			2015	9,074						14
15											15
16	Install new water heater			2016	18,700						16
17	Install tile flooring - Various corridors, nurses stations and specific residen			2016	63,430						17
18	rooms in the East, West and Center wings (Wings map attached)										18
19											19
20	New air compressor installed in fire sprinkle system			2017	2,740						20
21	Wall and floor rebuild - damaged by water			2017	2,615						21
22	Purchased water heater			2017	7,490						22
23	Replaced fire sprinkler piping - canopy			2017	6,928						23
24											24
25	Install rooftop 5-ton RTU unit			2018	18,970						25
26											26
27	Replace electrical panels			2019	4,429						27
28	Install new flooring and lighting in West Dining Room			2019	46,126						28
29	Installed R-38 blown cellulose insulation in Facility Attic			2019	38,406						29
30											30
31											31
32											32
33											33
34	C/O Allocation					23,230		23,230			34
35	Book Depreciation					223,597		223,597			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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Install concrete pad for dumpster	2020	13,000						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)		$ 7,959,613	$ 246,827		$ 246,827	$	$	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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 494,768	$ 63,620	$ 63,620	$		$	71
72	Current Year Purchases	10,461						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 505,229	$ 63,620	$ 63,620	$		$	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)	$ 9,144,729	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 319,002	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 319,002	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: 1/1/2020 Ending: 12/31/2020

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. [xx] 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:		99	2-1-2015	$ 640,110	27	0	3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 640,110 **			7

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

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

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.	/2021	$ 640,110
13.	/2022	$ 640,110
14.	/2023	$ 640,110

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: $ 56,257 Description: Televisions, copiers, oxygen cylinders, VAC wound care systems
(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: 1/1/2020 Ending: 12/31/2020

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	$		$ 224,019	$		$ 224,019	1
2	Licensed Speech and Language Development Therapist		hrs			62,520			62,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			230,880	0		230,880	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				254,845		254,845	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					23,098			23,098	13
14	TOTAL			$		$ 540,517	$ 254,845		$ 795,362	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:** 1/1/2020 **Ending:** 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 850,862	$	1
2	Cash-Patient Deposits	7,239		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	59,508		3
4	Supply Inventory (priced at FIFO)	69,542		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,662		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	492,581		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,491,394	$	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)**	$ 1,491,394	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 286,636	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,239		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	8,103		36
37	Deferred Stimulus	237,538		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 539,516	$	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)**	$ 539,516	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 951,878	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,491,394	$	48

***(See instructions.)**

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,406,330	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,406,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(454,452)	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)**	$ (454,452)	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)**	$ 951,878	24 *

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

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,712,455	1
2	Discounts and Allowances for all Levels	(2,255,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,456,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,965,247	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,965,247	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	460,873	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	485,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	843	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 946,724	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	97	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nurse aide training - refund	7,332	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,332	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,376,215	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,146,636	31
32	Health Care	2,792,161	32
33	General Administration	1,655,145	33
	B. Capital Expense		
34	Ownership	696,367	34
	C. Ancillary Expense		
35	Special Cost Centers	540,358	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)***	$ 6,830,667	40
41	**Income before Income Taxes (line 30 minus line 40)****	(454,452)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (454,452)	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: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,762	1,835	$ 69,946	$ 38.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,444	11,921	371,835	31.19	3
4	Licensed Practical Nurses	17,431	18,157	466,603	25.70	4
5	CNAs & Orderlies	59,345	61,818	939,122	15.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,499	6,770	84,893	12.54	10
11	Social Service Workers	1,762	1,835	39,733	21.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,188	19,987	248,097	12.41	15
16	Dishwashers					16
17	Maintenance Workers	8,227	8,570	124,321	14.51	17
18	Housekeepers	10,500	10,938	111,258	10.17	18
19	Laundry	4,051	4,220	45,660	10.82	19
20	Administrator	2,020	2,104	87,786	41.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,291	21,137	446,904	21.14	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)	162,520	169,292	$ 3,036,158 *	$ 17.93	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		$ 6,710	L1 C3	35
36	Medical Director		66,000	L9 C3	36
37	Medical Records Consultant		641	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,886	L10A C3	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 78,237		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 71,750	L10 C3	50
51	Licensed Practical Nurses		101,045	L10 C3	51
52	Certified Nurse Assistants/Aides		83,062	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 255,857		53

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shana Lister	Administrator		$ 87,786
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,786

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	Management	$ 285,845
May Cocagne & King	Audit & Tax	2,982
Legal adj to Zero		12,501
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 301,328

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,514
Unemployment Compensation Insurance	12,488
FICA Taxes	232,266
Employee Health Insurance	161,153
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	43,458
Central Office Allocation	41,501
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,380

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	3,395
Health Care Worker Background Check	
(Indicate # of checks performed)	3,140
Patient Background Checks	
PR	9,366
Dues & Subscriptions	14,822
License & Fees	2,552
Central Office Allocation	951
Less: Public Relations Expense	(9,366)
Non-allowable advertising	(2,970)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,890

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	964
	94
Seminar Expense	2,094
	1,847
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: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $5,940**

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

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

(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 **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** 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. $ **167,544**
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. $ **799**

(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? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **MCK CPA's & Advisors**

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

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

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009			PETTY CASH	850,862						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	59,508						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	0						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	11,662						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	69,542						
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	0						
1460			ACCUM DEPR-FURN & EQUIP	0						
1475			BUILDING & IMPROVEMENTS	0						
1490			ACCUM DEPR-BUILDING	0						
1530			RESIDENT FUNDS	7,239						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	492,581						
2010			ACCOUNTS PAYABLE	-286,636						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	0						
2110			ACCRUED VACATION PAY	0						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	0	0					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABL	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-8,103						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS							
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED STIMULUS	-237,538						
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-7,239						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-1,406,330						
2970			PROFIT/LOSS FOR PERIOD	454,452						
3007.1			PATIENT DAYS-PRIVATE	14,020						
3007.2			PATIENT DAYS-IPA	3,065						
3007.3			PATIENT DAYS-MEDICARE	3,538						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-5,712,455		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	0		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	0		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	0		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-485,008		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-1,965,247		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC	113,193						
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	2,255,640		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3452		10	HHS STIMULUS REVENUE	-460,873		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	0		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	-814		0	0	0	0	
3580		12	NURSE AIDE TRAINING REFUN	-7,332		0	0	0	0	
3590		1	EQUIPMENT RENTAL	0		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	22,939		0	0	0	0	
3600		21	MISC INCOME	-29		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	406,136	446,904	21	1	17	0	
4111			ADMINISTRATOR WAGES	87,786	87,786	17	1	0	0	
4115			VACATION & SICK - G&A	40,768		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	43,458	484,879	22	3	0	0	
4125			RESIDENT TRANSPORTATION	22,939	22,939	22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	0	113,193	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	0		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	33,220	33,220	21	2	0	0	
4260			TELEPHONE	13,696	13,696	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	180	180	23	3	16	0	**
4280			GENERAL TRAVEL	964	3,152	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	94		24	3	19	0	
4285			EDUCATION & SEMINAR	2,094		24	3	19	-3,307	***
4290			HELP WANTED ADVERTISING	3,395	99,918	20	3	0	0	-54,351
4291			PROMOTIONAL ADVERTISING	12,292		20	3	25	-12,292	
4292			PUBLIC RELATIONS	9,366		20	3	25	-9,366	
4300			LICENSES & FEES	56,903		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	14,822		20	3	17	-2,970	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	13,789	301,328	19	3	22	-2,982	
4355			MEDICAL DIRECTOR	66,000	66,000	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	641		10	3	0	0	
4363			PHARMACIST FEES	4,886		10	3	0	0	
4364			SOC SERV/ACT CONSULT	0	0	12	3	0	0	
4370			TV RENTAL	18,714		35	3	5	0	
4380			INCOME TAXES		23,130	27	3	26	0	
4383			BACKGROUND CHECKS	3,140		20	3	26	0	
4400			PAYROLL TAXES	244,754		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	161,153		22	3	0	0	
4420			LIABILITY INSURANCE	47,759	47,759	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	35,514		22	3	0	0	
4450			CENTRAL OFFICE FEES	287,539		19	3	34	0	**
4460			BAD DEBTS	21,000		27	3	24	-21,000	
4470			LOST ITEMS-RESIDENTS	609		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	37,543	56,257	35	3	16	0	
5110			MAINTENANCE SALARIES	114,232	124,321	6	1	0	0	
5120			MAINTENANCE SICK & VAC	10,089		6	1	0	0	
5130			ELECTRIC	85,528	128,576	5	3	0	0	
5131			NATURAL GAS	10,068		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	32,980		5	3	0	0	
5134			TRASH COLLECTION	17,474	134,259	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	10,141	77,087	6	2	0	0	
5160			GENERAL REPAIR & MAINT	66,946		6	2	0	0	
5165			MAINTENANCE CONTRACTS	116,785		6	3	0	0	
5210			DIETARY WAGES	233,477	248,097	1	1	0	0	
5220			DIETARY SICK & VAC	14,620		1	1	0	0	
5240			DIETARY CONSULTANT	6,710	6,710	2	3	13	0	
5248			FOOD PURCHASES	185,438	184,639	2	2	0	0	
5250			SUPPLIES-DISHWASHING	4,778	19,224	1	2	0	0	
5260			DIETARY REPLACEMENT	1,449		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	12,997		1	2	0	0	
5295			MEAL CREDIT	-799		2	2	0	0	
5310			LAUNDRY WAGES	43,069	45,660	4	1	0	0	
5340			LAUNDRY SICK & VAC	2,591		4	1	0	0	
5370			LAUNDRY REPLACEMENT	13,988	23,455	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	9,467		4	2	0	0	
5410			HOUSEKEEPING WAGES	106,701	111,258	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	4,557		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	43,350	43,350	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010			RN WAGES-MEDICARE		1,847,506	10	1	0	0	
6020			RN WAGES-NON MEDICARE	338,773		10	1	0	0	
6030			DON WAGES	69,946		10	1	0	0	
6035			ADON	0		10	1	0	0	
6040			RN SICK & VACATION	33,062		10	1	0	0	
6110			LPN WAGES-MEDICARE	442,819		10	1	0	0	
6120			LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	23,784		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	899,769		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	39,353		10	1	0	0	
6245			CONTRACT NURSES-RN	71,750		10	3	0	0	
6246			CONTRACT NURSES-LPN	101,045		10	3	0	0	
6247			CONTRACT NURSES-AIDES	83,062		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB			0	0	0	0	
6270			REHAB WAGES	0		10	1	0	0	
6275			REHAB SICK & VAC	0		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	10,483	200,613	10	2	0	0	
6295			NURSING SUPPLIES	166,288		10	2	0	0	
6390			REPLACEMENT-NURSING	23,842		10	2	0	0	
6490			NURSING OTHER	451	261,835	10	3	0	0	
7280			DRUG PURCHASES	254,845	254,845	39	2	0	0	***
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	23,098	23,098	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	78,814	84,893	11	1	0	0	
7540			ACTIVITIES SICK & VAC	6,079		11	1	0	0	
7590			ACTIVITIES SUPPLIES	11,236	11,236	11	2	0	0	
7595			ACTIVITIES FEES	0	0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	230,880	517,419	39	3	0	0	***
7660			PT SUPPLIES	0		39	2	0	0	
7710			SOCIAL SERVICE WAGES	32,795	39,733	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	6,938		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	2,402	2,402	12	2	0	0	
7740			OT FEE	224,019		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	62,520		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	0	0	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT	640,110	640,110	34	3	0	0	
8120			INTEREST EXPENSE	0	0	32	3	14	-97	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	
9510			INTEREST INCOME	-97		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	1,521		0	0	0	-1,521	
				6,717,377	6,830,667					
					113,290					
GRAND TOTALS				477,391					-53,535	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	162						
			BALANCE SHEET TOTAL	0						

1,009	1,009	CASH	850,862
1,100	1,100	ACCTS RE	152,932
1,101	1,101	ALLOW. F	(93,424)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,132	1,132	US HHS S	0
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID	231
1,220	1,220	OTHER PI	11,431
1,300	1,300	DIETARY I	69,542
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITUF	0
1,460			0
1,475	1,475	BUILDING:	0
1,490	1,490	ACCUM DI	0
1,530	1,530	RESIDENT	7,239
1,550	1,550	LOAN FEE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOI	492,581
2,010	2,010	ACCOUNT	(286,636)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEL	0
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEL	0
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	0
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GA	0
2,300	2,300	ACCRUEL	0
2,320	2,320	IPA PAYMI	(8,103)
2,350	2,350	REAL EST	0
2,385			(237,538)
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO R	(7,239)
2,600	2,600	LOC	0
2,600			0
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINEL	(1,406,330)
		net income	454,452
		balance	0

3,007	3,007	PATIENT I	14,020
3,007	3,007	PATIENT I	3,065
3,007	3,007	PATIENT I	3,538
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH	(5,712,455)
3,020	3,020	BASIC CH	0
3,030	3,030	BASIC CH	0
3,040		ASSESSM	113,193
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	0
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(485,008)
3,101			0
3,110	3,110	PHYSICAL	(1,965,247)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT TH	0
3,153	3,153	ST/OT TH	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHE	0
3,411	3,411	MEDICARI	0
3,420	3,420	MEDICARI	2,242,262
3,452	3,452	HHS STIM	(460,873)
3,520	3,520	RENT INC	0
3,530	3,530	BEAUTY S	0
3,560			0
3,570	3,570	VENDING	(814)
3,590	3,590	EQUIPMEI	0
3,595	3,595	RESIDENT	22,939
3,600	3,600	MISC INC	(29)
4,110	4,110	G&A WAG	406,136
4,111	4,111	ADMINISTI	87,786
4,115	4,115	G&A PTO	40,768
4,120	4,120	EMPLOYE	43,325
4,121			0
4,130	4,130	EMPLOYE	0
4,135	4,135	EMPLOYE	0
4,250	4,250	OFFICE S	7,200
4,255	4,255	POSTAGE	4,374
4,260	4,260	TELEPHO	13,696
4,275	4,275	TRAINING	180
4,276			0
4,280	4,280	GENERAL	964
4,281	4,281	MEAL EXF	94
4,285	4,285	EDUCATIC	1,473
4,289	4,289	MEETINGS	621
4,290	4,290	HELP WAI	3,395
4,291	4,291	PROMOTI	12,292
4,292	4,292	PUBLIC R	9,366
4,300	4,300	LICENSE	56,903
4,310	4,310	DUES & S	14,822
4,320	4,320	CONTRIBI	0
4,350	4,350	PROFESS	13,789
4,355	4,355	MEDICAL	66,000
4,362			641
4,363			4,886
4,364	4,364	SOCIAL S	0
4,370	4,370	TV RENTA	18,714
4,383	4,383	BACKGRC	3,140
4,390	4,390	OTHER TA	1,521
4,400	4,400	PAYROLL	244,754
4,401	4,401	PAYROLL	0
4,410	4,410	GROUP IN	161,153
4,420	4,420	LIABILITY I	47,759
4,430	4,430	WORKMA	32,654
4,435	4,435	W/C-FIRS	0
4,436	4,436	DRUG TE:	2,860
4,450	4,450	MANAGEM	287,539
4,460	4,460	BAD DEBT	21,000
4,461	4,461	BAD DEBT	13,378
4,470	4,470	LOST ITEI	609
4,475	4,475	UNIFORM	133
4,486	4,486	SERVICE	81,153
4,490	4,490	MISC EXP	292
4,496	4,496	MISC. M.I.:	21,646
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	37,543
5,110	5,110	MAINTENA	114,232
5,120	5,120	MAINTENA	10,089
5,130	5,130	ELECTRIC	85,528
5,131	5,131	NATURAL	10,068
5,133	5,133	WATER &	32,980
5,134	5,134	TRASH CC	17,474
5,140	5,140	PROP/PLA	10,141
5,160	5,160	GENERAL	66,946
5,165	5,165	MAINTENA	35,632
5,210	5,210	DIETARY	233,477
5,220	5,220	DIETARY I	14,620
5,248	5,248	FOOD PU	185,146
5,250	5,250	SUPPLIES	4,778
5,260	5,260	REPLACE	1,449
5,270	5,270	KITCHEN	12,997
5,295	5,295	MEAL INC	(799)
5,310	5,310	LAUNDRY	43,069
5,340	5,340	LAUNDRY	2,591
5,370	5,370	REPLACE	13,988
5,230	5,230	DIETARY	6,710
5,390	5,390	LAUNDRY	9,467
5,410	5,410	HOUSEKE	106,701
5,440	5,440	HOUSEKE	4,557
5,480	5,480	SUPPLIES	43,350
5,490	5,490	SUPPLIES	0
6,020	6,020	RN WAGE	338,773
6,030	6,030	DON WAG	69,946
6,035	6,035	ADON WA	0
6,040	6,040	RN PTO &	33,062
6,120	6,120	LPN WAG	442,819
6,140	6,140	LPN PTO	23,784
6,220	6,220	AIDES WA	899,769
6,240	6,240	AIDES PT	39,353
6,245		RN CONT	71,750
6,246		LPN CON	101,045
6,247		AIDES CO	83,062
6,250			0
6,255			0
6,260		AIDES TR	(7,332)
6,270	6,270	REHAB W	0
6,275	6,275	REHAB P	0
6,290	6,290	NURSING	10,483
6,295	6,295	NURSING	166,288
6,390	6,390	REPLACE	23,842
6,490	6,490	OTHER	451
7,280	7,280	DRUG PU	254,845
7,281	7,281	DRUG PU	0
7,380	7,380	LABORAT	17,530
7,391	7,390	X-RAY SE	5,568
7,393			0
7,510	7,510	ACTIVITIE	78,814
7,540	7,540	ACTIVITIE	6,079
7,590	7,590	ACTIVITIE	11,236
7,620	7,620	PHYSICAL	230,880
7,660	7,660	P.T. SUPF	0
7,710	7,710	SOCIAL S	32,795
7,720	7,720	SOCIAL S	6,938
7,730	7,730	SOCIAL S	2,402
7,740	7,740	OCCUPAT	224,019
7,750			
7,770	7,770	SPEECH	62,520
7,820	7,820	BEAUTICI	0
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			0
8,130	8,130	DEPRECI	0
8,150			0
9,510	9,510	INTEREST	(97)
9,520	9,520	MISC NON	0
9,530	4,220		0
	8,100		640,110
	9,702		0
	5,230		0
			454,452

Expenses Fixed Assets

0

Rutledge Regency Operations
IDPH ID# 53371
HFS Cost Report - December 31, 2020
Schedule V - Column 5 Reclassifications

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

Line Item		
Purchased Drugs and Medications	$	254,845
Purchased Hospital Services		1,276
Purchased Laboratory Services		17,530
Purchased Radiology Services		4,292
Amount Reclassified to Line 39	$	277,943

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

Line Item		
Provider Participation Fee - $1.50	$	(54,351)
Provider Assesment Fee - $6.07		(113,193)
	$	(167,544)
Provider Participation Fee	$	167,544

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consulting Fees

Line Item		
Pharmacy Consulting Fees	$	4,886