

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0053371</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Regency Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2120 W Washington St</u> <u>Springfield</u> <u>62702</u>																									
Number City Zip Code																									
County: <u>Sangamon</u>																									
Telephone Number: <u>(217)793-4880</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) () Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()											
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>David M Underwood</u>																								
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	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) () Fax # ()																								
Date of Initial License for Current Owners: <u>Feb 2015</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Dave Underwood</u> Telephone Number: <u>309 823-7135</u>																									
Email Address: _____																									

Facility Name & ID Number Regency Care

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

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	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	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>4</u>	Sheltered Care (SC)	<u>4</u>	<u>1,464</u>	5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	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	<u>2,686</u>	<u>20,932</u>	<u>4,366</u>	<u>27,984</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>522</u>		<u>522</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,686</u>	<u>21,454</u>	<u>4,366</u>	<u>28,506</u>	14

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

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 95 and days of care provided 4,366

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Regency Care # 0053371 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

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

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

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,745		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 79,745		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 13,144		37

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

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

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

Regency Care		
ID#	0053371	
Report Period Beginning:	01/01/16	
Ending:	12/31/16	

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(3,525)	27	20
21				21
22		(9,174)	19	22
23				23
24		(30,000)	27	24
25		(18,401)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(61,100)		49

STATE OF ILLINOIS

Summary A

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

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

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

STATE OF ILLINOIS

Summary B

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

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

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rutledge Joint Ventures LLC	99%	Heritage Health - Springfield	Springfield	Rutledge-Regency Rea	Springfield	Real Estate Holding
Rutledge - Regency Holdings LLC	1%			Heritage Operations G	Bloomington	Mgmt

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		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)	
1	V	19	Adjustment for Related Organiza	\$ 396,553	Heritage Operations Group LLC	0.00%	\$	\$ (396,553)	1
2	V	34	Adjustment for Related Organization	622,750	Rutledge-Regency Real Estate LLC	0.00%		(622,750)	2
3	V								3
4	V	33	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	115,376	115,376	4
5	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	239,472	239,472	5
6	V	30	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	270,871	270,871	6
7	V	32	Adjustment for Related Organization		Rutledge-Regency Real Estate LLC	0.00%	1,648	1,648	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,019,303			\$ 627,367	\$ * (391,936)	14

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

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.

YESNO

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

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

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 LLC		\$	0	15
16	V	30	Depreciation					28,158	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					302	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,116	20
21	V	35	Rent-Equipment & Vehicles					9,218	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ * 43,794	39

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

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

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

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

Facility Name & ID Number Regency Care# 0053371

Report Period Beginning:

01/01/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,571	26	\$ 134,491	\$ 133,835	99	\$ 5,179	1
2	2	Food Purchase	Beds	2,571	26	0	0	99	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	99	37	3
4	4	Laundry	Beds	2,571	26	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	99	1,609	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	99	21,668	6
7	7	Other	Beds	2,571	26	0	0	99	0	7
8	9	Medical Director	Beds	2,571	26	0	0	99	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	99	318	9
10	11	Activities	Beds	2,571	26	0	0	99	0	10
11	12	Social Service	Beds	2,571	26	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	99	1,276	12
13	14	Program Transportation	Beds	2,571	26	0	0	99	0	13
14	15	Other	Beds	2,571	26	0	0	99	0	14
15	17	Administrative	Beds	2,571	26	0	0	99	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	99	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	99	19,855	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	99	9,884	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	99	302,416	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	99	40,813	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	99	1,251	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	99	6,460	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	99	17,121	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 427,887	25

Ending: 12/31/16

()

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lancaster-Pollard		x	Mortgage			\$				\$	239,472	1
2												1,648	2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$	241,120	9
	B. Non-Facility Related*												
10	Interest Income											(672)	10
11	Central Office Allocation											302	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(370)	14
15	TOTALS (line 9+line14)						\$				\$	240,750	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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 2015 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	115,376 2
3. Under or (over) accrual (line 2 minus line 1).				\$	115,376 3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	115,376 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014	113,647	11	
		2015	115,376	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Care COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0053371

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(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. 14320101024		\$ 115,375.22	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 115,375.22	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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			2015	\$ 620,000	1
2					2
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										
10		Cabling for new IT systems	2015		40,016					
11		Phone system installation	2015		28,951					
12		Install (2) water heaters	2015		4,192					
13		Install new freezer	2015		4,961					
14		Install (2) new temering replacement valves	2015		3,284					
15		Rebuild roof where splits occurred	2015		9,074					
16										
17		Install new water heater	2016		18,700					
18		Install tile flooring - Various corridors, nurses stations and specific residen	2016		63,430					
19		rooms in the East, West and Center wings (Wings map attached)								
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33		C/O Allocation				28,158		28,158		
34		Book Depreciation				199,060		199,060		
35										
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Care

0053371

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,638,909	\$ 227,218		\$ 227,218	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 386,530	\$ 68,246	\$ 68,246	\$		\$	71
72	Current Year Purchases	75,714						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 462,244	\$ 68,246	\$ 68,246	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transports	2016 Ford E350	2016	\$ 59,887	\$ 3,565	\$ 3,565	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 59,887	\$ 3,565	\$ 3,565	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,781,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 299,029	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,029	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

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:				\$622,750	27		3
4	Additions							4
5								5
6								6
7	TOTAL				\$622,750			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 .
- 0

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: \$12,450 Description: Televisions
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

11. Rent to be paid in future years under the current rental agreement:
- | | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2017 | \$ |
| 13. | /2018 | \$ |
| 14. | /2019 | \$ |

* 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.)

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)	\$			

- (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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 403,066	\$		\$ 403,066	1
2	Licensed Speech and Language Development Therapist		hrs			66,190			66,190	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			373,357	0		373,357	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				742,916		742,916	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					22,322			22,322	13
14	TOTAL			\$		\$ 864,935	\$ 742,916		\$ 1,607,851	14

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

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

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

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 386,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,174		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	23,157		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 415,940	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 415,940	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,713,156	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,129,096	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 978,152	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 978,152	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	735,004	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 735,004	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,713,156	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Regency Care

0053371

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1

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

2

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

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

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

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

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

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

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	1,801	1,896	\$ 68,948	\$ 36.36	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,112	7,486	242,878	32.44	3
4	Licensed Practical Nurses	21,349	22,473	537,658	23.92	4
5	CNAs & Orderlies	59,597	62,734	849,025	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,641	4,885	73,779	15.10	8
9	Activity Director					9
10	Activity Assistants	4,923	5,182	68,213	13.16	10
11	Social Service Workers	1,835	1,932	42,170	21.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,668	19,651	250,745	12.76	15
16	Dishwashers					16
17	Maintenance Workers	6,186	6,512	92,770	14.25	17
18	Housekeepers	8,944	9,415	82,744	8.79	18
19	Laundry	4,020	4,232	41,231	9.74	19
20	Administrator	1,984	2,088	108,870	52.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,275	17,132	380,811	22.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,335	165,618	\$ 2,839,842 *	\$ 17.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		42,000		36
37	Medical Records Consultant		2,080		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,621		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,789		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,490		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Anthony Twardowski			\$ 108,870	Workers' Compensation Insurance	\$	89,888	IDPH License Fee	\$	
				Unemployment Compensation Insurance		29,227	Advertising: Employee Recruitment	14,351	
				FICA Taxes		217,248	Health Care Worker Background Check		
				Employee Health Insurance		131,727	(Indicate # of checks performed _____)	3,225	
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		17,465	PR	14,679	
(List each licensed administrator separately.)			\$ 108,870	Central Office Allocation		40,813	Dues & Subscriptions	3,531	
B. Administrative - Other							License & Fees	1,022	
Description			Amount				Central Office Allocation	9,884	
			\$				Less: Public Relations Expense	(14,679)	
							Non-allowable advertising	(729)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	526,368	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,284	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Heritage Operations Group	Mgt		\$ 392,533			\$	Out-of-State Travel	\$	
ADP	Payroll Tax Processing		911						
Sulaski & Webb	Audit & Tax		6,000						
Michigan Peer Review	Consulting		540				In-State Travel		
McKee Environmental	Asbestos Sampling		1,760					1,410	
								7	
							Seminar Expense	1,951	
								1,631	
Legal adj to Zero			9,174				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 410,918				TOTAL	\$ 4,999	

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number	Regency Care

XX. GENERAL INFORMATION:

- | | | |
|------|--|--------------------------------|
| (1) | Are nursing employees (RN,LPN,NA) represented by a union? | <u>No</u> |
| (2) | Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. | <u>No</u> |
| (3) | Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report? | <u>No</u> |
| (4) | Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity? | <u>No</u> |
| (5) | Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? | <u>Yes</u>
<u>7 Years</u> |
| (6) | Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. | \$ <u>5,000</u> Line <u>10</u> |
| (7) | Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation. | <u>Yes</u> |
| (8) | Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. | <u>No</u> |
| (9) | Are you presently operating under a sublease agreement? | YES <u>x</u> NO |
| (10) | Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. | YES NO <u>x</u> |
| (11) | Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V. | \$ <u>52,155</u> |
| (12) | Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation. | <u>No</u> |

GRAND TOTAL		475,000	48,000
	(NET INCOME)	0	
FACILITY NAME:			
FACILITY ID:			
FACILITY UNITS:	00		
BALANCE SHEET TOTAL		0	
	GA	30,000	BOLSA EXCHEN
BP	30,000	30,000	
PA	1,000	1,000	
MAINTEN	1,500	1,500	

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

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

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

Add (Subtract)

Reclassification of Provider Participation Fees

Provider Participation Fee - \$1.50	Line 20, Col 3	(52,155)
Provider Assesment Fee - \$6.07	Line 20, Col 3	<u>(143,294)</u>
		<u>(195,449)</u>
Provider Participation Fee	Line 42	<u>195,449</u>

Reclassification of Ancillary Services Cost

Cost of Drugs Purchased	Line 10(a), Col 2	(742,916)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	<u>(22,322)</u>
		<u>(765,238)</u>
Ancillary Service Centers	Line 39	<u>765,238</u>