

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0053371

Facility Name: Regency Care

Address: 2120 W Washington St Springfield 62702
Number City 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

Charitable Corp.

Trust

IRS Exemption Code

xx PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

xx Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 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)

(Type or Print Name) Daniel Curry

(Title) EVP & CFO

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

In the event there are further questions about this report, please contact:
Name: Daniel Curry Telephone Number: 309-823-7164
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	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	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	9,826	7,595	3,986	43	8,288	1,652	1,284	32,674	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	9,826	7,595	3,986	43	8,288	1,652	1,284	32,674	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 90.42%

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 ☒

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 Feb 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 certified beds. number of certified beds 99

Medicare Intermediary WPS

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	374,364	40,396	63,749	478,509		478,509	2,588	481,097			1
2	Food Purchase		272,727		272,727		272,727	2	272,729			2
3	Housekeeping	198,615	48,266		246,881		246,881		246,881			3
4	Laundry	65,952	42,903		108,855		108,855		108,855			4
5	Heat and Other Utilities			204,320	204,320		204,320	1,655	205,975			5
6	Maintenance	128,687	164,517	83,774	376,978		376,978	8,111	385,089			6
7	Other (specify):*											7
8	TOTAL General Services	767,618	568,809	351,843	1,688,270		1,688,270	12,356	1,700,626			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	2,495,977	124,916	1,053,823	3,674,716	82,949	3,757,665	(9,005)	3,748,660			10
10a	Therapy		225,235	19,375	244,610	(237,043)	7,567		7,567			10a
11	Activities	112,614	2,945		115,559		115,559		115,559			11
12	Social Services	61,618		5,941	67,559		67,559		67,559			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,670,209	353,096	1,121,139	4,144,444	(154,094)	3,990,350	(9,005)	3,981,345			16
	C. General Administration											
17	Administrative	103,240			103,240	50,159	153,399		153,399			17
18	Directors Fees											18
19	Professional Services			477,229	477,229		477,229	(458,345)	18,884			19
20	Dues, Fees, Subscriptions & Promotions			570,598	570,598	(487,160)	83,438	(24,498)	58,940			20
21	Clerical & General Office Expenses	346,604	61,023	154,034	561,661	(140,675)	420,986	138,488	559,474			21
22	Employee Benefits & Payroll Taxes			751,717	751,717		751,717	20,107	771,824			22
23	Inservice Training & Education			97	97		97	17	114			23
24	Travel and Seminar			7,445	7,445		7,445	(2,446)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			303,751	303,751		303,751	6,602	310,353			26
27	Other (specify):* Lost Resident Items			263,960	263,960		263,960	(263,927)	33			27
28	TOTAL General Administration	449,844	61,023	2,528,831	3,039,698	(577,676)	2,462,022	(584,002)	1,878,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,887,671	982,928	4,001,813	8,872,412	(731,770)	8,140,642	(580,651)	7,559,991			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							275,987	275,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,805	6,805		6,805	168,436	175,241			32
33	Real Estate Taxes							117,530	117,530			33
34	Rent-Facility & Grounds			647,647	647,647		647,647	(643,572)	4,075			34
35	Rent-Equipment & Vehicles			47,269	47,269		47,269	2,591	49,860			35
36	Other (specify):*											36
37	TOTAL Ownership			701,721	701,721		701,721	(79,028)	622,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			436,226	436,226	244,610	680,836	468,661	1,149,497			39
40	Barber and Beauty Shops			517	517		517		517			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					487,160	487,160		487,160			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			436,743	436,743	731,770	1,168,513	468,661	1,637,174			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,887,671	982,928	5,140,277	10,010,876		10,010,876	(191,018)	9,819,858			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	(412)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(819)			13
14	Non-Care Related Interest	(6,805)			14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(9,108)			17
18	Fines and Penalties	(163,155)			18
19	Entertainment	(486)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,135)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,953)			24
25	Fund Raising, Advertising and Promotional	(17,851)			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 Fees charged to wrong facility	(5,610)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (308,334)		\$	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)	117,316		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 117,316		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (191,018)		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	xx		10,408	10a	42
43	Prescription Drugs	xx		225,235	10a	43
44	Hospital Services	xx		8,967	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 244,610		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (8,613)	20
2	Other Expenses Related to Lobbying Activities		
3			
4			
5			
6			
7			
8			
9			
10			
11	(99,953)	27	
12	(819)	27	
13	(163,155)	27	
14	(9,238)	20	
15	(9,108)	20	
16	(4,135)	19	
17	(486)	24	
18	(412)	32	
19	(6,805)	32	
20	(5,610)	10	
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49	Total	(308,334)	

Summary A

12/31/2025

[illegible]

Summary B

0053371

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

[illegible]

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	None		Heritage Operations G	Bloomington	Mgmt. Services
Rutledge - Regency Holdings LLC	1			Green Tree Pharmacy	Minonk	Pharmacy
				Rutledge Regency Real	Bloomington	Real Estate Holding
				Memorial Medical Cen	Springfield	Hospital

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			\$			\$	\$	1
2	V	33	Adjustment for Related Organization		Rutledge Regency Real Estate LLC		117,530	117,530	2
3	V	32	Adjustment for Related Organization		Rutledge Regency Real Estate LLC		174,005	174,005	3
4	V	30	Adjustment for Related Organization		Rutledge Regency Real Estate LLC		272,286	272,286	4
5	V	32	Adjustment for Related Organization		Rutledge Regency Real Estate LLC		1,648	1,648	5
6	V								6
7	V	19	Adjustment for Related Organization	456,411	Heritage Operations Group, LLC			(456,411)	7
8	V								8
9	V	39	Adjustment for Related Organization		GreenTree Pharmacy		468,661	468,661	9
10	V	10	Adjustment for Related Organization		GreenTree Pharmacy		(3,775)	(3,775)	10
11	V								11
12	V	34	Adjustment for Related Organization	647,647	Rutledge Regency Real Estate LLC			(647,647)	12
13	V								13
14	Total			\$ 1,104,058			\$ 1,030,355	\$ * (73,703)	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.

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Operations Group		\$	\$ 2,588	15
16	V	2	Food Purchase		Heritage Operations Group			2	16
17	V	3	Housekeeping		Heritage Operations Group			0	17
18	V	4	Laundry		Heritage Operations Group			0	18
19	V	5	Heat & Other Utilities		Heritage Operations Group			1,655	19
20	V	6	Maintenance		Heritage Operations Group			8,111	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			380	23
24	V	11	Activities		Heritage Operations Group			0	24
25	V	12	Social Service		Heritage Operations Group			0	25
26	V	13	Nurse Aide Training		Heritage Operations Group			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			2,201	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group			2,461	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group			138,488	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group			20,107	34
35	V	23	Inservice Training & Education		Heritage Operations Group			17	35
36	V	24	Travel and Seminar		Heritage Operations Group			(1,960)	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group			6,602	38
39	Total			\$			\$ 0	\$ * 180,652	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Operations Group		\$	0	15
16	V	30	Depreciation		Heritage Operations Group			3,701	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32	Interest		Heritage Operations Group			0	18
19	V	33	Real Estate Taxes		Heritage Operations Group			0	19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group			4,075	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group			2,591	21
22	V	36	Other		Heritage Operations Group			0	22
23	V	38	Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39	Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41	Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42	Provider Participation Fee		Heritage Operations Group			0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ * 10,367	39

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

STATE OF ILLINOIS				Ownership Listing-1			
Regency Care		ID#		0053371			
Report Period Beginning:		01/01/2025				Heritage Operations Gr	
Ending:		12/31/2025				Rutledge Regency Real Estate LLC	
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)						Management	
-Owners of companies must be listed instead of company names.				Operator/Licensee		Building Co.	
-Names of trust beneficiaries must be listed.				Ownership Percentage		Ownership Percentage	
First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1							1
2		Memorial Health Ventures, Inc. -					2
3		Owned by Memorial Health System,					3
4		an Illinois not for profit corporation	Springfield	IL	50.00000	50.00000	4
5							5
6							6
7							7
8	Craig	Hart Trust	Hudson	IL	14.21000	14.21000	28.42000
9	Joseph	Warner Trust	Bloomington	IL	2.00000	2.00000	4.00000
10	Linda	Hagi Trust	Bloomington	IL	1.20500	1.20500	2.41000
11	Janice	Hart Trust	Streator	IL	1.20500	1.20500	2.41000
12	Timothy	Jefferson	Champaign	IL	8.05000	8.05000	16.10000
13	Paul	Jefferson	Bloomington	IL	8.05000	8.05000	16.10000
14	Robert	Dickson Family Trust	Naples	IL	0.64000	0.64000	1.28000
15	Cheryl	Lowney	Lincoln	IL	0.38500	0.38500	0.77000
16	Steven	Wannemacher	Bloomington	IL	0.92500	0.92500	1.85000
17	Bruce	Hart	Phoenix	IL	3.65350	3.65350	7.30700
18	Brian	Hart	Lake Forest	IL	3.65350	3.65350	7.30700
19	Benjamin	Hart Trust	Bloomington	IL	3.65350	3.65350	7.30700
20	Jerry	Westwood Trust	Naples	IL	0.80000	0.80000	1.60000
21	Van	Freiderich	Congerville	IL	0.35000	0.35000	0.70000
22	Todd	Hart Trust	Bloomington	IL	0.34500	0.34500	0.69000
23	Allan	Hart	Morton	IL	0.34500	0.34500	0.69000
24	Connie	Hoselton	Lexington	IL	0.17000	0.17000	0.34000
25	David	Fehrenbacher	Lincoln	IL	0.04000	0.04000	0.08000
26	David	Wegman	Normal	IL	0.04000	0.04000	0.08000
27	David	Hoeper	Fishers	IL	0.02500	0.02500	0.05000
28	David	Underwood	Peoria	IL	0.04000	0.04000	0.08000
29	Jane	Hart Trust	Hudson	IL	0.21500	0.21500	0.43000
30							30
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75							75

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	None								\$		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: 01/01/2025 Ending: 2/31/2025

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 115 W Jefferson Street Ste 401
City / State / Zip Code Bloomington IL 61701
Phone Number (309-828-4361
Fax Number (309-829-5477

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Licensed Beds	1,740	19	\$ 45,492	\$ 45,492	99	\$ 2,588	1
2	2	Food Purchase	Licensed Beds	1,740	19	33	0	99	2	2
3	3	Housekeeping	Licensed Beds	1,740	19	0	0	99	0	3
4	4	Laundry	Licensed Beds	1,740	19	0	0	99	0	4
5	5	Heat & Other Utilities	Licensed Beds	1,740	19	29,087	0	99	1,655	5
6	6	Maintenance	Licensed Beds	1,740	19	142,553	16,750	99	8,111	6
7	7	Other	Licensed Beds	1,740	19	0	0	99	0	7
8	9	Medical Director	Licensed Beds	1,740	19	0	0	99	0	8
9	10	Nursing & Medical Records	Licensed Beds	1,740	19	6,679	2,741	99	380	9
10	11	Activities	Licensed Beds	1,740	19	0	0	99	0	10
11	12	Social Service	Licensed Beds	1,740	19	0	0	99	0	11
12	13	Nurse Aide Training	Licensed Beds	1,740	19	0	0	99	0	12
13	14	Program Transportation	Licensed Beds	1,740	19	0	0	99	0	13
14	15	Other	Licensed Beds	1,740	19	0	0	99	0	14
15	17	Administrative	Licensed Beds	1,740	19	0	0	99	0	15
16	18	Directors Fees	Licensed Beds	1,740	19	0	0	99	0	16
17	19	Professional Services	Licensed Beds	1,740	19	38,683	0	99	2,201	17
18	20	Fees, Subscription, Promotions	Licensed Beds	1,740	19	43,255	0	99	2,461	18
19	21	Clerical & General Office Expense	Licensed Beds	1,740	19	2,434,037	2,368,749	99	138,488	19
20	22	Employee Benefits & Payroll Tax	Licensed Beds	1,740	19	353,400	0	99	20,107	20
21	23	Inservic Training & Education	Licensed Beds	1,740	19	297	0	99	17	21
22	24	Travel and Seminar	Licensed Beds	1,740	19	(34,448)	0	99	(1,960)	22
23	25	Other Admin. Staff Transportatio	Licensed Beds	1,740	19	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Licensed Beds	1,740	19	116,027	0	99	6,602	24
25	TOTALS					\$ 3,175,095	\$ 2,433,732		\$ 180,652	25

Facility Name & ID Number Regency Care # 0053371 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 115 W Jefferson Street Ste 401
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Phone Number (309-828-4361
Fax Number (309-829-5477

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Licensed Beds	1,740	19	\$	\$	99	\$	1
2	30	Depreciation	Licensed Beds	1,740	19	65,049		99	3,701	2
3	31	Amortization of Pre-Op & Org	Licensed Beds	1,740	19			99		3
4	32	Interest	Licensed Beds	1,740	19			99		4
5	33	Real Estate Taxes	Licensed Beds	1,740	19			99		5
6	34	Rent-Facility & Grounds	Licensed Beds	1,740	19	71,614		99	4,075	6
7	35	Rent-Equipment & Vehicles	Licensed Beds	1,740	19	45,533		99	2,591	7
8	36	Other	Licensed Beds	1,740	19			99		8
9	38	Medically Nec Transportation	Licensed Beds	1,740	19			99		9
10	39	Ancillary Service Centers	Licensed Beds	1,740	19			99		10
11	40	Barber and Beauty Shops	Licensed Beds	1,740	19			99		11
12	41	Coffee and Gift Shops	Licensed Beds	1,740	19			99		12
13	42	Provider Participation Fee	Licensed Beds	1,740	19			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					\$ 182,196	\$		\$ 10,367	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lument (fka Lancaster Pollard)		xx	Mortgage (HUD Financed)			\$	4,498,198			\$	174,005	1
2												1,648	2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	4,498,198			\$	175,653	9
	B. Non-Facility Related*												
10	Interest Income											(412)	10
11	Interest on CMP fines											6,805	11
12	Adjustment to interest on CMP fines											(6,805)	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(412)	14
15	TOTALS (line 9+line14)						\$	4,498,198			\$	175,241	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,951 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.)

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.

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. List the bed capacity for the building if it differs from the licensed total. Same
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Nursing Facility		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	\$		\$	\$	4
5			2015		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 resident rooms in the East, West and Center wings (Wings map attached)			2016	63,430					17
18										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					3,701		3,701		34
35	Book Depreciation					263,869		263,869		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Care

0053371

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Install concrete pad for dumpster	2020	\$ 13,000	\$		\$	\$	\$	37
38									38
39	Replace fuel tank	2021	14,083						39
40	Install split system	2021	9,634						40
41	Replace door closer	2021	2,553						41
42	Repalce flooring in resident lounge	2021	2,988						42
43	Install rubber roof coating	2021	5,800						43
44	Overlay parking lot	2021	57,125						44
45	Install 4 ton split system - Activity Room	2021	9,700						45
46	Install 3 ton split system - Break Room	2021	8,675						46
47									47
48	Replace dry valve - sprinkler system	2022	7,427						48
49	Replace PTAC unit	2022	2,954						49
50									50
51	Replace water damaged windows and install (2) Pella windows	2023	8,510						51
52	Remodel shower in Room 209 -	2023	6,166						52
53	New shower valve								53
54	Demolish and dispose existing walls								54
55	Install new waterproof walls, new tile and PVC protective								55
56	board								56
57	Replaced pump controller	2023	4,794						57
58	Repaired and replaced water damaged soffit/fascia/gutter	2023	9,433						58
59	Replaced HVAC rooftop unit - kitchen	2023	11,975						59
60	Heat pump replacement - laundry	2023	11,655						60
61	Repaired generator	2023	3,631						61
62	Refabricated front entry railing	2023	2,670						62
63									63
64	Replaced heat exchanger assembly, burners and limit switch on	2024	3,315						64
65	100/200 Hall rooftop Carrier air unit								65
66	Replaced (3) electromechanical door closer/holders	2024	5,982						66
67	Furnished and installed (6) round ceiling fire dampers and	2024	10,249						67
68	(1) square fire damper for kitchen storage								68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,158,932	\$ 267,570		\$ 267,570	\$	\$	70

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

Facility Name & ID Number Regency Care

0053371

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 8,158,932	\$ 267,570		\$ 267,570	\$	\$	1
2	Extended (3) existing emergency power circuits to new	2024	2,600						2
3	locations within the building; added a new circuit for a								3
4	kitchen island plate warmer								4
5	Removed and loaded unnecessary silt in and along retention	2024	4,780						5
6	pond; installed fabric as needed and PVC drain line								6
7	Installed new 6 inch seamless gutters with corresponding	2024	23,130						7
8	downspouts								8
9	Replaced bottom row of ceramic tile in (3) showers with	2024	10,440						9
10	Jelly Sheet vinyl which was placed on top of the existing mosaic floor								10
11	Replaced defective frequency drive for blower motor on	2024	4,184						11
12	main lobby carrier package unit								12
13									13
14	Upgraded equipment, wiring and other infrastructure	2025	39,020						14
15	related to the nurse call system								15
16	Upgraded damaged wiring and replaced alarm system	2025	24,588						16
17	in the elevator								17
18	Repaired animal damage to the wall flashings and stucco	2025	4,564						18
19	top of the canopy which covers the drive-through								19
20	Nurse Station - replace vinyl tile with Shaw Expo plank	2025	22,540						20
21	flooring								21
22	Roof - Replaced entire flat section of roofing. Replacement	2025	305,398						22
23	necessitated by age of existing roof section. Replacement roof consists of new								23
24	single-ply synthetic rubber membrane (EPDM)								24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,600,176	\$ 267,570		\$ 267,570	\$	\$	34

**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	\$ 459,328	\$ 8,417	\$ 8,417	\$		\$	71
72	Current Year Purchases	15,980						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 475,308	\$ 8,417	\$ 8,417	\$		\$	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	Various	2016 Ford E350	2016	\$ 59,887	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 59,887	\$	\$	\$		\$	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)	\$ 9,755,371	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 275,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,987	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:		99	Feb 2015	\$ 647,647			3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 647,647			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 ☐ 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: \$ 47,269 Description: Oxygen concentrators, copiers and printers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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	\$		\$ 213,552	\$		\$ 213,552	1
2	Licensed Speech and Language Development Therapist		hrs			41,428			41,428	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			181,246	0		181,246	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				225,235		225,235	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					19,375			19,375	13
14	TOTAL			\$		\$ 455,601	\$ 225,235		\$ 680,836	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 130,918	\$	1
2	Cash-Patient Deposits	12,342		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,141,661		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,101		6
7	Other Prepaid Expenses	14,109		7
8	Accounts Receivable (owners or related parties)	(143,316)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,158,815	\$	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): <u>Investment in Trinity RRG</u>	12,535		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,535	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,171,350	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 592,637	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,342		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	44,294		36
37	<u>Accrued Insurance Liability</u>	250,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 899,273	\$	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)	\$ 899,273	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 272,077	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,171,350	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,094,653	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,094,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(826,117)	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) Additional Paid In Capital	3,541	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (822,576)	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)	\$ 272,077	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Regency Care

0053371

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 9,028,897	1
2	Discounts and Allowances for all Levels	(1,319,912)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,708,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,102,706	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,102,706	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	108,859	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	322,321	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,860	19
20	Radiology and X-Ray	996	20
21	Other Medical Services	33,620	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 472,656	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	412	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 412	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Extraordinary Item - Claims Reserve Reversal</u>	(100,000)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (100,000)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,184,759	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,688,270	31
32	Health Care	4,144,444	32
33	General Administration	3,039,698	33
	B. Capital Expense		
34	Ownership	701,721	34
	C. Ancillary Expense		
35	Special Cost Centers	436,743	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)*	\$ 10,010,876	40
41	Income before Income Taxes (line 30 minus line 40)**	(826,117)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (826,117)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,145,388.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,679,891.38	45
46	MMAI-Medicaid is the Primary Payer	881,699.62	46
47	MMAI-Medicare is the Primary Payer	19,070.00	47
48	Private Pay	2,127,875.65	48
49	Medicare Part A	562,968.00	49
50	Other-(specify) <u>Private Insurance</u>	329,539.35	50
51	Other-(specify) <u>Equipment Rental</u>	11,879.00	51
52	Other-(specify) <u>Medicare Cost Report Settlement</u>	56,679.00	52
53	Other-(specify) <u>Medicare Bad Debts</u>	-106,005.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,708,985	56

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	2,291	2,412	\$ 118,640	\$ 49.19	1
2	Assistant Director of Nursing	4,422	4,655	199,239	42.80	2
3	Registered Nurses	6,565	6,911	310,686	44.96	3
4	Licensed Practical Nurses	10,592	11,150	374,355	33.57	4
5	CNAs & Orderlies	58,135	61,195	1,493,057	24.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,522	5,813	112,614	19.37	10
11	Social Service Workers	2,056	2,165	61,618	28.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,768	18,703	374,364	20.02	15
16	Dishwashers					16
17	Maintenance Workers	5,901	6,212	128,687	20.72	17
18	Housekeepers	9,711	10,222	198,615	19.43	18
19	Laundry	3,610	3,800	65,952	17.36	19
20	Administrator	1,504	1,583	103,240	65.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,450	14,158	346,604	24.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	141,527	148,979	\$ 3,887,671 *	\$ 26.10	34

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		\$ 9,939	Ln 1 Col 3	35
36	Medical Director		42,000	Ln 9 Col 3	36
37	Medical Records Consultant		1,579	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,567	Ln 10a Col 3	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		5,941	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 67,026		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,278	\$ 404,269	Ln10 Col 3	50
51	Licensed Practical Nurses	2,411	150,036	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	7,567	263,849	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	15,256	\$ 818,154		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberRegency Care# 0053371Report Period Beginning: 01/01/2025Ending: 12/31/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

NameFunctionOwnership%

Tammy RileyAdministrator\$54,513

Shelley TulipanaAdministrator48,727

TOTAL (agree to Schedule V, line 17, col. 1)
(List each licensed administrator separately.)\$103,240

B. Administrative - Other

DescriptionAmount

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

C. Professional Services

Vendor/PayeeTypeAmount

Heritage Operations GroupManagement459,084

MCK CPA & AdvisorsAudit & Tax9,860

Pivotal ConsultingQuality Measures1,800

David FehrenbacherMedicare consulting1,000

David UnderwoodPublic Aid consulting1,350

Legal adj to Zero4,135

TOTAL (agree to Schedule V, line 19, column 3)
(For legal fee disclosure, see page 39 of instructions)\$477,229

D. Employee Benefits and Payroll Taxes

DescriptionAmount

Workers' Compensation Insurance\$37,491

Unemployment Compensation Insurance27,081

FICA Taxes297,407

Employee Health Insurance377,548

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits12,190

Central Office Allocation20,107

TOTAL (agree to Schedule V, line 22, col.8)\$771,824

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

DescriptionLine #Amount

TOTAL\$

F. Dues, Fees, Subscriptions and Promotions

DescriptionAmount

IDPH License Fee\$

Advertising: Employee Recruitment9,171

Health Care Worker Background Check
(Indicate # of checks performed)2,459

Patient Background Checks

Association Dues (total from pg 22, #4)17,226

517

36,214

Central Office Allocation2,461

Less: Public Relations Expense ()

PAC and Lobbying payments(8,613)

All non-allowable advertising(495)

TOTAL (agree to Sch. V, line 20, col. 8)\$58,940

G. Schedule of Travel and Seminar**

DescriptionAmount

Out-of-State Travel\$

In-State Travel6,476

Central Office Allocation(1,960)

Seminar Expense969

(486)

Entertainment Expense ()

TOTAL (agree to Sch. V, line 24, col. 8)\$4,999

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	8,613
	8,613 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	8,613
	8,613 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	17,226
	17,226 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 5,000 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 487,160

This amount is to be recorded on line 42 of Schedule V.
- (8) 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.
- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 466
- (12) 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. \$
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: MCK CPA's & Advisors Yes
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) 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.

	GL	Code Ref	Sub Exp	Sub Exp Desc	4 exp Adjustment		Code Ref	Sub Exp	Sub Exp Desc	4 exp Adjustment
1100	PLTY CARD	130.00				1000	1.00B CASH	100.00		
1101	CASH ON HAND	130.00				1100	1.10B ACTS RECE	100.00		
1102	ACCOUNTS RECEIVABLE	1,001.00				1101	1.10B ACTS RECE	100.00		
1103	ACCOUNTS RECEIVABLE	1,001.00				1102	1.10B ACTS RECE	100.00		
1104	ACCOUNTS RECEIVABLE	1,001.00				1103	1.10B ACTS RECE	100.00		
1105	ACCOUNTS RECEIVABLE	1,001.00				1104	1.10B ACTS RECE	100.00		
1106	ACCOUNTS RECEIVABLE	1,001.00				1105	1.10B ACTS RECE	100.00		
1107	ACCOUNTS RECEIVABLE	1,001.00				1106	1.10B ACTS RECE	100.00		
1108	ACCOUNTS RECEIVABLE	1,001.00				1107	1.10B ACTS RECE	100.00		
1109	ACCOUNTS RECEIVABLE	1,001.00				1108	1.10B ACTS RECE	100.00		
1110	ACCOUNTS RECEIVABLE	1,001.00				1109	1.10B ACTS RECE	100.00		
1111	ACCOUNTS RECEIVABLE	1,001.00				1110	1.10B ACTS RECE	100.00		
1112	ACCOUNTS RECEIVABLE	1,001.00				1111	1.10B ACTS RECE	100.00		
1113	ACCOUNTS RECEIVABLE	1,001.00				1112	1.10B ACTS RECE	100.00		
1114	ACCOUNTS RECEIVABLE	1,001.00				1113	1.10B ACTS RECE	100.00		
1115	ACCOUNTS RECEIVABLE	1,001.00				1114	1.10B ACTS RECE	100.00		
1116	ACCOUNTS RECEIVABLE	1,001.00				1115	1.10B ACTS RECE	100.00		
1117	ACCOUNTS RECEIVABLE	1,001.00				1116	1.10B ACTS RECE	100.00		
1118	ACCOUNTS RECEIVABLE	1,001.00				1117	1.10B ACTS RECE	100.00		
1119	ACCOUNTS RECEIVABLE	1,001.00				1118	1.10B ACTS RECE	100.00		
1120	ACCOUNTS RECEIVABLE	1,001.00				1119	1.10B ACTS RECE	100.00		
1121	ACCOUNTS RECEIVABLE	1,001.00				1120	1.10B ACTS RECE	100.00		
1122	ACCOUNTS RECEIVABLE	1,001.00				1121	1.10B ACTS RECE	100.00		
1123	ACCOUNTS RECEIVABLE	1,001.00				1122	1.10B ACTS RECE	100.00		
1124	ACCOUNTS RECEIVABLE	1,001.00				1123	1.10B ACTS RECE	100.00		
1125	ACCOUNTS RECEIVABLE	1,001.00				1124	1.10B ACTS RECE	100.00		
1126	ACCOUNTS RECEIVABLE	1,001.00				1125	1.10B ACTS RECE	100.00		
1127	ACCOUNTS RECEIVABLE	1,001.00				1126	1.10B ACTS RECE	100.00		
1128	ACCOUNTS RECEIVABLE	1,001.00				1127	1.10B ACTS RECE	100.00		
1129	ACCOUNTS RECEIVABLE	1,001.00				1128	1.10B ACTS RECE	100.00		
1130	ACCOUNTS RECEIVABLE	1,001.00				1129	1.10B ACTS RECE	100.00		
1131	ACCOUNTS RECEIVABLE	1,001.00				1130	1.10B ACTS RECE	100.00		
1132	ACCOUNTS RECEIVABLE	1,001.00				1131	1.10B ACTS RECE	100.00		
1133	ACCOUNTS RECEIVABLE	1,001.00				1132	1.10B ACTS RECE	100.00		
1134	ACCOUNTS RECEIVABLE	1,001.00				1133	1.10B ACTS RECE	100.00		
1135	ACCOUNTS RECEIVABLE	1,001.00				1134	1.10B ACTS RECE	100.00		
1136	ACCOUNTS RECEIVABLE	1,001.00				1135	1.10B ACTS RECE	100.00		
1137	ACCOUNTS RECEIVABLE	1,001.00				1136	1.10B ACTS RECE	100.00		
1138	ACCOUNTS RECEIVABLE	1,001.00				1137	1.10B ACTS RECE	100.00		
1139	ACCOUNTS RECEIVABLE	1,001.00				1138	1.10B ACTS RECE	100.00		
1140	ACCOUNTS RECEIVABLE	1,001.00				1139	1.10B ACTS RECE	100.00		
1141	ACCOUNTS RECEIVABLE	1,001.00				1140	1.10B ACTS RECE	100.00		
1142	ACCOUNTS RECEIVABLE	1,001.00				1141	1.10B ACTS RECE	100.00		
1143	ACCOUNTS RECEIVABLE	1,001.00				1142	1.10B ACTS RECE	100.00		
1144	ACCOUNTS RECEIVABLE	1,001.00				1143	1.10B ACTS RECE	100.00		
1145	ACCOUNTS RECEIVABLE	1,001.00				1144	1.10B ACTS RECE	100.00		
1146	ACCOUNTS RECEIVABLE	1,001.00				1145	1.10B ACTS RECE	100.00		
1147	ACCOUNTS RECEIVABLE	1,001.00				1146	1.10B ACTS RECE	100.00		
1148	ACCOUNTS RECEIVABLE	1,001.00				1147	1.10B ACTS RECE	100.00		
1149	ACCOUNTS RECEIVABLE	1,001.00				1148	1.10B ACTS RECE	100.00		
1150	ACCOUNTS RECEIVABLE	1,001.00				1149	1.10B ACTS RECE	100.00		
1151	ACCOUNTS RECEIVABLE	1,001.00				1150	1.10B ACTS RECE	100.00		
1152	ACCOUNTS RECEIVABLE	1,001.00				1151	1.10B ACTS RECE	100.00		
1153	ACCOUNTS RECEIVABLE	1,001.00				1152	1.10B ACTS RECE	100.00		
1154	ACCOUNTS RECEIVABLE	1,001.00				1153	1.10B ACTS RECE	100.00		
1155	ACCOUNTS RECEIVABLE	1,001.00				1154	1.10B ACTS RECE	100.00		
1156	ACCOUNTS RECEIVABLE	1,001.00				1155	1.10B ACTS RECE	100.00		
1157	ACCOUNTS RECEIVABLE	1,001.00				1156	1.10B ACTS RECE	100.00		
1158	ACCOUNTS RECEIVABLE	1,001.00				1157	1.10B ACTS RECE	100.00		
1159	ACCOUNTS RECEIVABLE	1,001.00				1158	1.10B ACTS RECE	100.00		
1160	ACCOUNTS RECEIVABLE	1,001.00				1159	1.10B ACTS RECE	100.00		
1161	ACCOUNTS RECEIVABLE	1,001.00				1160	1.10B ACTS RECE	100.00		
1162	ACCOUNTS RECEIVABLE	1,001.00				1161	1.10B ACTS RECE	100.00		
1163	ACCOUNTS RECEIVABLE	1,001.00				1162	1.10B ACTS RECE	100.00		
1164	ACCOUNTS RECEIVABLE	1,001.00				1163	1.10B ACTS RECE	100.00		
1165	ACCOUNTS RECEIVABLE	1,001.00				1164	1.10B ACTS RECE	100.00		
1166	ACCOUNTS RECEIVABLE	1,001.00				1165	1.10B ACTS RECE	100.00		
1167	ACCOUNTS RECEIVABLE	1,001.00				1166	1.10B ACTS RECE	100.00		
1168	ACCOUNTS RECEIVABLE	1,001.00				1167	1.10B ACTS RECE	100.00		
1169	ACCOUNTS RECEIVABLE	1,001.00				1168	1.10B ACTS RECE	100.00		
1170	ACCOUNTS RECEIVABLE	1,001.00				1169	1.10B ACTS RECE	100.00		
1171	ACCOUNTS RECEIVABLE	1,001.00				1170	1.10B ACTS RECE	100.00		
1172	ACCOUNTS RECEIVABLE	1,001.00				1171	1.10B ACTS RECE	100.00		
1173	ACCOUNTS RECEIVABLE	1,001.00				1172	1.10B ACTS RECE	100.00		
1174	ACCOUNTS RECEIVABLE	1,001.00				1173	1.10B ACTS RECE	100.00		
1175	ACCOUNTS RECEIVABLE	1,001.00				1174	1.10B ACTS RECE	100.00		
1176	ACCOUNTS RECEIVABLE	1,001.00				1175	1.10B ACTS RECE	100.00		
1177	ACCOUNTS RECEIVABLE	1,001.00				1176	1.10B ACTS RECE	100.00		
1178	ACCOUNTS RECEIVABLE	1,001.00				1177	1.10B ACTS RECE	100.00		
1179	ACCOUNTS RECEIVABLE	1,001.00				1178	1.10B ACTS RECE	100.00		
1180	ACCOUNTS RECEIVABLE	1,001.00				1179	1.10B ACTS RECE	100.00		
1181	ACCOUNTS RECEIVABLE	1,001.00				1180	1.10B ACTS RECE	100.00		
1182	ACCOUNTS RECEIVABLE	1,001.00				1181	1.10B ACTS RECE	100.00		
1183	ACCOUNTS RECEIVABLE	1,001.00				1182	1.10B ACTS RECE	100.00		
1184	ACCOUNTS RECEIVABLE	1,001.00				1183	1.10B ACTS RECE	100.00		
1185	ACCOUNTS RECEIVABLE	1,001.00				1184	1.10B ACTS RECE	100.00		
1186	ACCOUNTS RECEIVABLE	1,001.00				1185	1.10B ACTS RECE	100.00		
1187	ACCOUNTS RECEIVABLE	1,001.00				1186	1.10B ACTS RECE	100.00		
1188	ACCOUNTS RECEIVABLE	1,001.00				1187	1.10B ACTS RECE	100.00		
1189	ACCOUNTS RECEIVABLE	1,001.00				1188	1.10B ACTS RECE	100.00		
1190	ACCOUNTS RECEIVABLE	1,001.00				1189	1.10B ACTS RECE	100.00		
1191	ACCOUNTS RECEIVABLE	1,001.00				1190	1.10B ACTS RECE	100.00		
1192	ACCOUNTS RECEIVABLE	1,001.00				1191	1.10B ACTS RECE	100.00		
1193	ACCOUNTS RECEIVABLE	1,001.00				1192	1.10B ACTS RECE	100.00		
1194	ACCOUNTS RECEIVABLE	1,001.00				1193	1.10B ACTS RECE	100.00		
1195	ACCOUNTS RECEIVABLE	1,001.00				1194	1.10B ACTS RECE	100.00		
1196	ACCOUNTS RECEIVABLE	1,001.00				1195	1.10B ACTS RECE	100.00		
1197	ACCOUNTS RECEIVABLE	1,001.00				1196	1.10B ACTS RECE	100.00		
1198	ACCOUNTS RECEIVABLE	1,001.00				1197	1.10B ACTS RECE	100.00		
1199	ACCOUNTS RECEIVABLE	1,001.00				1198	1.10B ACTS RECE	100.00		
1200	ACCOUNTS RECEIVABLE	1,001.00				1199	1.10B ACTS RECE	100.00		
1201	ACCOUNTS RECEIVABLE	1,001.00				1200	1.10B ACTS RECE	100.00		
1202	ACCOUNTS RECEIVABLE	1,001.00				1201	1.10B ACTS RECE	100.00		
1203	ACCOUNTS RECEIVABLE	1,001.00				1202	1.10B ACTS RECE	100.00		
1204	ACCOUNTS RECEIVABLE	1,001.00				1203	1.10B ACTS RECE	100.00		
1205	ACCOUNTS RECEIVABLE	1,001.00				1204	1.10B ACTS RECE	100.00		
1206	ACCOUNTS RECEIVABLE	1,001.00				1205	1.10B ACTS RECE	100.00		
1207	ACCOUNTS RECEIVABLE	1,001.00				1206	1.10B ACTS RECE	100.00		
1208	ACCOUNTS RECEIVABLE	1,001.00				1207	1.10B ACTS RECE	100.00		
1209	ACCOUNTS RECEIVABLE	1,001.00				1208	1.10B ACTS RECE	100.00		
1210	ACCOUNTS RECEIVABLE	1,001.00				1209	1.10B ACTS RECE	100.00		
1211	ACCOUNTS RECEIVABLE	1,001.00				1210	1.10B ACTS RECE	100.00		
1212	ACCOUNTS RECEIVABLE	1,001.00				1211	1.10B ACTS RECE	100.00		
1213	ACCOUNTS RECEIVABLE	1,001.00				1212	1.10B ACTS RECE	100.00		
1214	ACCOUNTS RECEIVABLE	1,001.00				1213	1.10B ACTS RECE	100.00		
1215	ACCOUNTS RECEIVABLE	1,001.00				1214	1.10B ACTS RECE	100.00		
1216	ACCOUNTS RECEIVABLE	1,001.00				1215	1.10B ACTS RECE	100.00		
1217	ACCOUNTS RECEIVABLE	1,001.00				1216	1.10B ACTS RECE	100.00		
1218	ACCOUNTS RECEIVABLE	1,001.00				1217	1.10B ACTS RECE	100.00		
1219	ACCOUNTS RECEIVABLE	1,001.00				1218	1.10B ACTS RECE	100.00		
1220	ACCOUNTS RECEIVABLE	1,001.00				1219	1.10B ACTS RECE	100.00		
1221	ACCOUNTS RECEIVABLE	1,001.00				1220	1.10B ACTS RECE	100.00		
1222	ACCOUNTS RECEIVABLE	1,001.00				1221	1.10B ACTS RECE	100.00		
1223	ACCOUNTS RECEIVABLE	1,001.00				1222	1.10B ACTS RECE	100.00		
1224	ACCOUNTS RECEIVABLE	1,001.00				1223	1.10B ACTS RECE	100.00		
1225	ACCOUNTS RECEIVABLE	1,001.00				1224	1.10B ACTS RECE	100.00		
1226	ACCOUNTS RECEIVABLE	1,001.00				1225	1.10B ACTS RECE	100.00		
1227	ACCOUNTS RECEIVABLE	1,001.00				1226	1.10B ACTS RECE	100.00		
1228	ACCOUNTS RECEIVABLE	1,001.00				1227	1.10B ACTS RECE	100.00		
1229	ACCOUNTS RECEIVABLE	1,001.00				1228	1.10B ACTS RECE	100.00		
1230	ACCOUNTS RECEIVABLE	1,001.00				1229	1.10B ACTS RECE	100.00		
1231	ACCOUNTS RECEIVABLE	1,001.00				1230	1.10B ACTS RECE	100.00		
1232	ACCOUNTS RECEIVABLE	1,001.00				1231	1.10B ACTS RECE	100.00		
1233	ACCOUNTS RECEIVABLE	1,001.00				1232	1.10B ACTS RECE	100.00		
1234	ACCOUNTS RECEIVABLE	1,001.00				1233	1.10B ACTS RECE	100.00		
1235	ACCOUNTS RECEIVABLE	1,001.00				1234	1.10B ACTS RECE	100.00		
1236	ACCOUNTS RECEIVABLE	1,001.00				1235	1.10B ACTS RECE	100.00		
1237	ACCOUNTS RECEIVABLE	1,001.00				1236	1.10B ACTS RECE	100.00		
1238	ACCOUNTS RECEIVABLE	1,001.								

Rutledge Regency Operations LLC
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	225,235
Purchased Hospital Services		8,967
Purchased Laboratory Services		5,247
Purchased Radiology Services		5,161
Amount Reclassified to Line 39	\$	<u><u>244,610</u></u>

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

<u>Line Item</u>		
Provider Participation Fee		<u><u>487,160</u></u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant Cost

<u>Line Item</u>		
Pharmacy Consultant	\$	<u><u>7,567</u></u>

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>		
MDS Coordinators/Care Planners - Line 21, Col 1	\$	(113,567)
Medical Records Specialists - Line 21, Col 1		<u>(27,108)</u>
		<u><u>(140,675)</u></u>
Nursing & Medical Records Line 10		<u><u>140,675</u></u>

5. Schedule V - Line 10, Column 3 to Line 17 - Reclass Fees Paid For Interim Administrator Service

<u>Line Item</u>		
Nursing - Other	\$	<u><u>50,159</u></u>