

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 N/A

	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	300	Skilled (SNF)	300	109,500	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	300	TOTALS	300	109,500	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,860	4,159	7,019	22,038	8
9	SNF/PED					9
10	ICF	39,589	25,790		65,379	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,449	29,949	7,019	87,417	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.83%

D. How many bed-hold days during this year were paid by Public Aid? None (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)
N/A

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 05/13/76

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/30/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 6,842

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE # 0022418 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	420,639	57,816	21,681	500,136		500,136		500,136		1
2	Food Purchase		430,336		430,336	(52,195)	378,141	(1,460)	376,681		2
3	Housekeeping	291,959	37,974		329,933		329,933		329,933		3
4	Laundry	116,647	35,424	700	152,771		152,771		152,771		4
5	Heat and Other Utilities			226,607	226,607		226,607	595	227,202		5
6	Maintenance	111,756	28,554	69,951	210,261		210,261	(28,808)	181,453		6
7	Other (specify):*										7
8	TOTAL General Services	941,001	590,104	318,939	1,850,044	(52,195)	1,797,849	(29,673)	1,768,176		8
	B. Health Care and Programs										
9	Medical Director			46,000	46,000		46,000		46,000		9
10	Nursing and Medical Records	3,428,181	293,298	89,203	3,810,682		3,810,682	404	3,811,086		10
10a	Therapy	68,827	363	844	70,034		70,034	4,074	74,108		10a
11	Activities	164,858	8,896	1,234	174,988		174,988		174,988		11
12	Social Services	164,108		3,200	167,308		167,308		167,308		12
13	Nurse Aide Training										13
14	Program Transportation			1,174	1,174		1,174	261	1,435		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,825,974	302,557	141,655	4,270,186		4,270,186	4,739	4,274,925		16
	C. General Administration										
17	Administrative	180,891		445,250	626,141		626,141	(29,829)	596,312		17
18	Directors Fees										18
19	Professional Services			120,980	120,980	(19,599)	101,381	(9,054)	92,327		19
20	Dues, Fees, Subscriptions & Promotions			191,652	191,652		191,652	(138,137)	53,515		20
21	Clerical & General Office Expenses	292,773	100,731	105,055	498,559		498,559	(79,461)	419,098		21
22	Employee Benefits & Payroll Taxes			1,175,454	1,175,454	52,195	1,227,649		1,227,649		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,662	2,662		2,662	(358)	2,304		24
25	Other Admin. Staff Transportation			1,873	1,873		1,873		1,873		25
26	Insurance-Prop.Liab.Malpractice			254,401	254,401		254,401	939	255,340		26
27	Other (specify):*							17,052	17,052		27
28	TOTAL General Administration	473,664	100,731	2,297,327	2,871,722	32,596	2,904,318	(238,848)	2,665,470		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,240,639	993,392	2,757,921	8,991,952	(19,599)	8,972,353	(263,782)	8,708,571		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			165,468	165,468		165,468	94,945	260,413			30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)				31
32	Interest			107,130	107,130		107,130	392,160	499,290			32
33	Real Estate Taxes			384,218	384,218	19,599	403,817	11,798	415,615			33
34	Rent-Facility & Grounds			1,154,100	1,154,100		1,154,100	(1,154,100)				34
35	Rent-Equipment & Vehicles			29,864	29,864		29,864		29,864			35
36	Other (specify):*											36
37	TOTAL Ownership			1,851,484	1,851,484	19,599	1,871,083	(665,901)	1,205,182			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	96,758	49,436	87,915	234,109		234,109	5,021	239,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	34,649			34,649		34,649	(60,125)	(25,476)			43
44	TOTAL Special Cost Centers	131,407	49,436	252,165	433,008		433,008	(55,104)	377,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,372,046	1,042,828	4,861,570	11,276,444		11,276,444	(984,786)	10,291,658			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(43,363)	30		9
10	Interest and Other Investment Income	(20,332)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,460)	02		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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,499)	21		24
25	Fund Raising, Advertising and Promotional	(21,862)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,917)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(111,727)	20		28
29	Other-Attach Schedule	(152,343)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (428,503)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(556,284)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (556,284)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (984,786)		37

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

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

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

OHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: 01/01/02
 Ending: 12/31/02

NON-ALLOWABLE EXPENSES	Amount	Reference
1 Non-Allowable Legal Fees	(1,803)	19
2 Regency At-Home Care - Interest Expense	(4,041)	22
3 Regency At-Home Health - Interest Expense	(5,210)	22
4 COPE Dues	(5,211)	20
5 Veterans Expense	(170)	10
6 Bank Charges	(4,005)	21
7 Promotional/Marketing	(60,125)	43
8 Amortization of Loan Acquisition Cost	(10,764)	31
9 Funeral Director Cost	(775)	21
10 Collections	(10,542)	19
11 Web Design	(974)	19
12 Non-Allowable Seminar Expense	(250)	24
13 Capitalized Repairs & Maintenance	(31,363)	6
14 Non-Care Depreciation	(3,636)	30
15 Non-Allowable Related Party Interest	(1,672)	22
16 Out of Period Professional Fees	(138)	19
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101 Total	(152,343)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE# 0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

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													1
2	Food Purchase	(1,460)											(1,460)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			272		323							595	5
6	Maintenance	(31,363)		1,083		1,472							(28,808)	6
7	Other (specify):*													7
8	TOTAL General Services	(32,823)		1,355		1,795							(29,673)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(170)				574							404	10
10a	Therapy					4,074							4,074	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation					261							261	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(170)				4,909							4,739	16
	C. General Administration													
17	Administrative				(29,829)								(29,829)	17
18	Directors Fees													18
19	Professional Services	(13,457)		183	2,228	1,992							(9,054)	19
20	Fees, Subscriptions & Promotions	(138,810)		70	26	577							(138,137)	20
21	Clerical & General Office Expenses	(81,696)		19	531	1,685							(79,461)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(358)											(358)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			429		510							939	26
27	Other (specify):*				17,052								17,052	27
28	TOTAL General Administration	(234,321)		701	(9,992)	4,764							(238,848)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(267,314)		2,056	(9,992)	11,468							(263,782)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE # 0022418 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(46,999)	134,359	3,489		4,096							94,945	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(43,361)	417,151	4,698		13,672							392,160	32
33	Real Estate Taxes			5,387		6,411							11,798	33
34	Rent-Facility & Grounds		(1,032,000)	(122,100)									(1,154,100)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(101,064)	(480,490)	(108,526)		24,179							(665,901)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					5,021							5,021	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,125)											(60,125)	43
44	TOTAL Special Cost Centers	(60,125)				5,021							(55,104)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(428,503)	(480,490)	(106,470)	(9,992)	40,668							(984,786)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kenneth Nieman	33.34	None		Regency Mgmt	Niles	Mgmt. Co.
Benjamin Rogow	33.33	None		KNR Partnership	Niles	Building Co.
Lothar Kahn	33.33	None		Regency Rehab.	Niles	Therapy Co.
				Regency Building	Niles	Building Co.

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	34 Rent	\$ 1,032,000	Regency Building	100.00%	\$	\$ (1,032,000)	1
2	V	30 Depreciation		Regency Building		134,359	134,359	2
3	V	32 Interest		Regency Building		417,151	417,151	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,032,000			\$ 551,510	\$ * (480,490)	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	5 UTILITIES	\$	KNR ENTERPRISES	100.00%	\$ 272	\$ 272
16	V	6 REPAIRS AND MAINT.		KNR ENTERPRISES		1,083	1,083
17	V	19 PROFESSIONAL FEES		KNR ENTERPRISES		183	183
18	V	20 DUES AND SUBS.		KNR ENTERPRISES		70	70
19	V	21 CLERICAL		KNR ENTERPRISES		19	19
20	V	26 INSURANCE		KNR ENTERPRISES		429	429
21	V	30 DEPRECIATION		KNR ENTERPRISES		3,063	3,063
22	V	32 INTEREST EXPENSE		KNR ENTERPRISES		4,698	4,698
23	V	33 REAL ESTATE TAXES		KNR ENTERPRISES		5,167	5,167
24	V	33 R. ESTATE TAX-PROTEST FEES		KNR ENTERPRISES		220	220
25	V						
26	V	34 RENT	122,100	KNR ENTERPRISES			(122,100)
27	V						
28	V						
29	V	30 DEPRECIATION		KNR ENTERPRISES		426	426
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 122,100			\$ 15,630	\$ * (106,470)

* 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	19 PROFESSIONAL FEES	\$	REGENCY MANAGEMENT CORP.	100.00%	\$ 2,228	\$ 2,228	15
16	V	20 DUES, SUBSCRIPTIONS		REGENCY MANAGEMENT CORP.		26	26	16
17	V	21 CLERICAL AND GENERAL		REGENCY MANAGEMENT CORP.		531	531	17
18	V							18
19	V	17 MANAGEMENT FEES	435,250	REGENCY MANAGEMENT CORP.			(435,250)	19
20	V			REGENCY MANAGEMENT CORP.				20
21	V							21
22	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		149,617	149,617	22
23	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		6,293	6,293	23
24	V							24
25	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		136,429	136,429	25
26	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,738	5,738	26
27	V							27
28	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		119,375	119,375	28
29	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,021	5,021	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		\$ 435,250			\$ 425,258	\$ * (9,992)	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	5 UTILITIES	\$	REGENCY REHABILITATION SERVICES, INC.	100.00%	\$ 323	\$	323	15
16	V	6 REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		1,472		1,472	16
17	V	10 NURSING		REGENCY REHABILITATION SERVICES, INC.		574		574	17
18	V	10a THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		4,074		4,074	18
19	V	14 PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.		261		261	19
20	V	19 PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		1,992		1,992	20
21	V	20 DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		577		577	21
22	V	21 CLERICAL		REGENCY REHABILITATION SERVICES, INC.		1,685		1,685	22
23	V	26 INSURANCE		REGENCY REHABILITATION SERVICES, INC.		510		510	23
24	V	30 DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		4,096		4,096	24
25	V	32 INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		13,672		13,672	25
26	V	33 REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		6,411		6,411	26
27	V	39 THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		49,645		49,645	27
28	V								28
29	V								29
30	V								30
31	V	39 PHYSICAL THERAPY	44,624	REGENCY REHABILITATION SERVICES, INC.				(44,624)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 44,624			\$ 85,292	\$ *	40,668	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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			\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							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		\$			\$	\$ *	39

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE # 0022418 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	Kenneth Neiman	President	Admin	33.34%	None	10	25.00%	Mgmt Fee	\$ 119,375	17-7	1
2	Benjamin Rogow	Vice President	Admin	33.33%	None	47	78.33%	Mgmt Fee	149,617	17-7	2
3	Lothar Kahn	Secretary	Admin	33.33%	None	15	37.50%	Mgmt Fee	136,429	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 405,421		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 KNR ENTERPRISES
 Street Address 6625 N MILWAKEE
 City / State / Zip Code NILES, IL 60714
 Phone Number (847) 647 - 1166
 Fax Number (847) 588 - 1330

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	5	UTILITIES	SQUARE FOOTAGE	6,654	4	\$ 2,934	\$ 616	\$ 272	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	11,703	616	1,083	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	1,975	616	183	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4	757	616	70	4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4	200	616	19	5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	4,629	616	429	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	33,086	616	3,063	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	50,745	616	4,698	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	55,817	616	5,167	9
10	33	R. ESTATE TAX-PROTEST FEE	SQUARE FOOTAGE	6,654	4	2,375	616	220	10
11									11
12									12
13									13
14									14
15	30	DEPRECIATION	DIRECT ALLOCATION	6,654	4	4,212		426	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 168,433	\$	\$ 15,630	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 REGENCY MANAGEMENT CORP
 Street Address 6021 N. LAWDALE
 City / State / Zip Code CHICAGO IL 60659
 Phone Number (847) 647 - 1116
 Fax Number (847) 588 - 1330

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	19	PROFESSIONAL FEES	MNGMNT. FEE INC.	859,250	2	\$ 4,300	\$ 445,250	\$ 2,228	1	
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	859,250	2	50	445,250	26	2	
3	21	CLERICAL AND GENERAL	MNGMNT. FEE INC.	859,250	2	1,025	445,250	531	3	
4									4	
5									5	
6									6	
7									7	
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	191,000	191,000	47	149,617	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	8,033	47	6,293	9	
10									10	
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	191,000	191,000	15	136,429	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	8,033	15	5,738	12	
13									13	
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	191,000	191,000	10	119,375	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	8,033	10	5,021	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 602,474	\$ 573,000	\$ 425,258	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending: 12/31/02

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 REGENCY REHAB SERVICES
 Street Address 6625 N MILWAKEE
 City / State / Zip Code NILES, IL 60714
 Phone Number (847) 647 - 1116
 Fax Number (847) 588 - 1330

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	5	UTILITIES	THERAPY INCOME	60,321	3	\$ 437	\$ 44,624	\$ 323	1
2	6	REPAIRS AND MAINT.	THERAPY INCOME	60,321	3	1,990	44,624	1,472	2
3	10	NURSING	THERAPY INCOME	60,321	3	775	44,624	574	3
4	10-a	THERAPY CONSULTANTS	THERAPY INCOME	60,321	3	5,508	44,624	4,074	4
5	14	PROGRAM TRANSPORTATION	THERAPY INCOME	60,321	3	353	44,624	261	5
6	19	PROFESSIONAL FEES	THERAPY INCOME	60,321	3	2,693	44,624	1,992	6
7	20	DUES AND SUBS.	THERAPY INCOME	60,321	3	780	44,624	577	7
8	21	CLERICAL	THERAPY INCOME	60,321	3	2,278	44,624	1,685	8
9	26	INSURANCE	THERAPY INCOME	60,321	3	689	44,624	510	9
10	30	DEPRECIATION	THERAPY INCOME	60,321	3	5,537	44,624	4,096	10
11	32	INTEREST EXPENSE	THERAPY INCOME	60,321	3	18,481	44,624	13,672	11
12	33	REAL ESTATE TAXES	THERAPY INCOME	60,321	3	8,667	44,624	6,411	12
13	39	THERAPY SALARY & BENEFIT	THERAPY INCOME	60,321	3	67,109	55,657	49,645	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					\$ 115,296	\$ 55,657	\$ 85,292	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending: 12/31/02

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Bank One		X	Line of Credit		01/01/00	\$ 1,090,000	\$ 645,000	01/01/03	4.25%	\$ 35,487	1								
2	Northern Life Insurance		X	Mortgage	\$64,500.00	03/01/95	6,000,000	4,397,349	03/01/10	10.00%	417,151	2								
3	Regency Venture		X	Second Mortgage	\$19,542.00	05/30/81	2,405,912	684,150	05/01/06	7.73%	62,286	3								
4												4								
5												5								
Working Capital																				
6	Regency At-Home Care	X		Working Capital	None			27,594	Demand	IRS Rate	4,041	6								
7	Regency At-Home Health	X		Working Capital	None			242,341	Demand	IRS Rate	5,316	7								
8												8								
9	TOTAL Facility Related				\$84,042.00		\$ 9,495,912	\$ 5,996,434			\$ 524,281	9								
B. Non-Facility Related*																				
10	See Supplemental Schedule										(15,634)	10								
11	Regency At-Home Care			Non-Allowed							(4,041)	11								
12	Regency At-Home Health			Non-Allowed							(5,316)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (24,991)	14								
15	TOTALS (line 9+line14)						\$ 9,495,912	\$ 5,996,434			\$ 499,290	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

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

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

Facility Name & ID Number

REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

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	Reporting Period Interest Expense									
										Name of Lender		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										Related**	YES				NO	Original			
1	Allocation - KNR Partnership	X									\$ 4,698	1							
2	Allocation - Regency Rehab.	X									13,672	2							
3	Non-Allow - Regency Rehab.										(13,672)	3							
4	Interest Income										(20,332)	4							
5												5							
6												6							
7												7							
8												8							
9												9							
10												10							
11												11							
12												12							
13												13							
14												14							
15												15							
16												16							
17												17							
18												18							
19												19							
20												20							
21											\$ (15,634)	21							

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REGENCY HLTHCARE & REHAB CTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-31-401-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,709.17</u>	\$ <u>3,709.17</u>
2. <u>10-31-401-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>85,469.14</u>	\$ <u>85,469.14</u>
3. <u>10-31-401-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>107,299.77</u>	\$ <u>107,299.77</u>
4. <u>10-31-401-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>107,299.77</u>	\$ <u>107,299.77</u>
5. <u>10-31-401-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>85,439.68</u>	\$ <u>85,439.68</u>
6. <u>See Attached</u>	<u>See Attached</u>	\$ <u>53,317.00</u>	\$ <u>10,810.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>442,534.53</u>	\$ <u>400,027.53</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME REGENCY HLTHCARE & REHAB CTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>See Attached</u>	<u>See Attached</u>	\$ <u>53,317.00</u>	\$ <u>10,810.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>53,317.00</u>	\$ <u>10,810.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02 Ending:

12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,591 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

- Regency At-Home Health Services, Ltd. - Home Health Agency - Separate Building
- Regency At-Home Care Service, Ltd. - Home Health and Adult Day Care Agency - Separate Building
- Regency Rehabilitation Service Ltd. - Rehabilitation Company - Separate Building

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>4/30/1981</u>	<u>\$ 450,000</u>	1
2					2
3	TOTALS			\$ 450,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1981	\$ 3,708,375	\$ 134,359	35	\$ 123,613	\$ (10,746)	\$ 1,204,026	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	2,440		20	46	46	1,502	9
10	Various			1995	55,899		20	2,796	2,796	21,210	10
11	Various			1996	143,243		20	7,167	7,167	46,027	11
12	Various			1997	109,626		20	5,484	5,484	31,069	12
13	Various			1998	546,842		20	27,342	27,342	115,688	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$ -	\$	\$ -	37		
38					-		-	38		
39					-		-	39		
40					-		-	40		
41					-		-	41		
42					-		-	42		
43					-		-	43		
44					-		-	44		
45					-		-	45		
46					-		-	46		
47					-		-	47		
48					-		-	48		
49					-		-	49		
50					-		-	50		
51					-		-	51		
52					-		-	52		
53					-		-	53		
54					-		-	54		
55					-		-	55		
56					-		-	56		
57					-		-	57		
58					-		-	58		
59					-		-	59		
60					-		-	60		
61					-		-	61		
62					-		-	62		
63					-		-	63		
64					-		-	64		
65					-		-	65		
66					-		-	66		
67					-		-	67		
68	<u>Related Party Allocations (Page 12-REP & Page 12A-REP)</u>		<u>291,253</u>		<u>9,240</u>		<u>1,656</u>	<u>72,059</u>	68	
69	<u>Financial Statement Depreciation</u>				<u>161,831</u>		<u>(161,831)</u>		69	
70	TOTAL (lines 4 thru 69)		\$ 4,857,678		\$ 303,774		\$ 175,688	\$ (128,086)	\$ 1,491,581	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		\$ 4,857,678	\$ 303,774		\$ 175,688	\$ (128,086)	\$ 1,491,581	1
2	DOOR-HARDWARE	1999	2,830		20	142	142	568	2
3	WALL LAMPS	1999	194		20	10	10	39	3
4	LOBBY RENOVATION	1999	13,351		20	668	668	2,616	4
5	WALL LAMPS	1999	10,342		20	517	517	2,068	5
6	SIGN	1999	8,180		20	409	409	1,568	6
7	DISPENSER	1999	212		20	11	11	42	7
8	NURSE CALL SYSTEM	1999	491		20	25	25	92	8
9	CARPET	1999	600		20	30	30	113	9
10	BLINDS	1999	1,377		20	69	69	259	10
11	DRAPE	1999	169		20	8	8	30	11
12	VALVES	1999	2,518		20	126	126	473	12
13	ELEVATOR	1999	834		20	42	42	161	13
14	CONST-3 & 5 FLOOR	1999	11,200		20	560	560	2,193	14
15	FLOURESCENT FIXTURES	1999	4,200		20	210	210	753	15
16	SIGN ELECTRICAL	1999	750		20	38	38	136	16
17	TUBE BUNDLE	1999	1,257		20	63	63	252	17
18	WALLPAPER	1999	2,406		20	120	120	440	18
19	SHOWER PRESSURE VALV	1999	2,766		20	138	138	552	19
20	PLUMBING REPAIRS	1999	1,200		20	60	60	240	20
21	NATURAL GAS	1999	826		20	41	41	150	21
22	NATURAL GAS	1999	866		20	43	43	165	22
23	COMPRESSOR	1999	23,902		20	1,195	1,195	4,083	23
24	WALLPAPER	1999	2,219		20	111	111	379	24
25	WALLPAPER	1999	249		20	12	12	39	25
26	OUTLET, FIXTURE	1999	14,159		20	708	708	2,360	26
27	IMPERIAL BOOSTER	1999	3,297		20	165	165	550	27
28	FLOURESCENT FIXTURE	1999	7,700		20	385	385	1,219	28
29	LIMESTONE	1999	1,410		20	71	71	225	29
30	PANELS	1999	1,365		20	68	68	210	30
31	BORDERS	1999	3,029		20	151	151	491	31
32	SIGNS	1999	1,041		20	52	52	178	32
33	BATH TUB REPAIR	1999	870		20	44	44	172	33
34	TOTAL (lines 1 thru 33)		\$ 4,983,488	\$ 303,774		\$ 181,980	\$ (121,794)	\$ 1,514,397	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	
1	Totals from Page 12B, Carried Forward		\$ 4,983,488	\$ 303,774		\$ 181,980	\$ (121,794)	\$ 1,514,397	1
2	REPLACE VINYL TILE	1999	1,829		20	91	91	356	2
3	PHONE SYSTEM	1999	10,922		20	546	546	1,729	3
4	ALARM SYSTEM	1999	3,888		20	194	194	598	4
5	WATER PUMP	2000	2,981		20	149	149	447	5
6	FLUORESCENT FIXTURES	2000	11,750		20	588	588	1,764	6
7	FLUORESCENT FIXTURES	2000	13,350		20	668	668	2,004	7
8	BLINDS	2000	1,500		20	75	75	213	8
9	FLAME PROOF DRAPES	2000	544		20	27	27	77	9
10	CABLE FRAMES	2000	4,979		20	249	249	726	10
11	BLINDS	2000	1,751		20	88	88	249	11
12	WALLPAPER	2000	4,422		20	221	221	645	12
13	WIRING	2000	1,015		20	51	51	145	13
14	MOTOR STARTER	2000	1,024		20	51	51	136	14
15	TIME CLOCK	2000	1,185		20	59	59	152	15
16	SUMP PUMPS	2000	4,241		20	212	212	530	16
17	CARPET METAL	2000	234		20	12	12	28	17
18	DIALYSIS CIRCUITS	2000	3,300		20	165	165	371	18
19	SOAP DISPENSER	2000	950		20	48	48	104	19
20	MISC ELECTRICAL	2000	7,200		20	360	360	780	20
21	FIRE ALARM SYSTEM	2000	520		20	26	26	67	21
22	AIR HANDLER REPAIR	2000	658		20	33	33	99	22
23	SMOKE DETECTOR	2000	650		20	33	33	74	23
24	CABLE	2000	361		20	18	18	72	24
25	CABLE & JACKS	2000	11,148		20	557	557	1,950	25
26	TELEPHONE	2000	9,900		20	495	495	1,320	26
27	ANTENA SYSTEM	2000	15,203		20	760	760	1,900	27
28	ELECTRICAL	2001	4,000		20	200	200	400	28
29	ELECTRICAL	2001	6,900		20	345	345	690	29
30	EMERGENCY PHONE	2001	11,500		20	575	575	1,150	30
31	LIGHT FIXTURES	2001	3,825		20	191	191	366	31
32	LIGHT FIXTURES	2001	3,075		20	154	154	244	32
33	ELECTRICAL	2001	4,500		20	225	225	338	33
34	TOTAL (lines 1 thru 33)		\$ 5,132,793	\$ 303,774		\$ 189,446	\$ (114,328)	\$ 1,534,121	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12C, Carried Forward		\$ 5,132,793	\$ 303,774		\$ 189,446	\$ (114,328)	\$ 1,534,121	1
2	LIGHT FIXTURES	2001	2,250		20	113	113	170	2
3	ELEC-4TH FLR FM RM	2001	5,000		20	250	250	396	3
4	ELEC-5TH FLR FAM RM	2001	5,000		20	250	250	375	4
5	ELECTRICAL	2001	1,906		20	95	95	143	5
6	LIGHT FIXTURES	2001	2,250		20	113	113	170	6
7	ELEC-3RD FLR FAM RM	2001	5,000		20	250	250	375	7
8	ASPHALT - PARK LOT	2001	21,917		20	1,096	1,096	1,644	8
9	ELEC-2ND FLR FAM RM	2001	5,000		20	250	250	354	9
10	LIGHT FIXT - 2ND FLR	2001	2,250		20	113	113	160	10
11	LIGHT FIXTURES-5TH F	2001	2,250		20	113	113	160	11
12	ELEC - 1ST FLR FAM F	2001	5,000		20	250	250	354	12
13	FLOORING	2001	1,567		20	78	78	111	13
14	INTERIOR GLASS	2001	6,982		20	349	349	465	14
15	LIGHT FIXTURES	2001	1,495		20	75	75	100	15
16	RADIO	2001	1,295		20	65	65	76	16
17	ARCHITECT FEES	2001	864		20	43	43	47	17
18	SATELLITE SYSTEM	2001	3,790		20	190	190	380	18
19	SATELITE SYSTEM	2001	4,596		20	230	230	441	19
20	DOOR-DIALYSIS ROOM	2002	1,450		20	145	145	145	20
21	ELECTRICAL	2002	7,904		20	659	659	659	21
22	PLUMBING-DIALYSIS ROOM	2002	30,850		20	2,571	2,571	2,571	22
23	CIRCUIT PANELBOARD	2002	23,500		20	1,567	1,567	1,567	23
24	DIALYSIS ROOM	2002	10,550		20	615	615	615	24
25	DRAPES	2002	5,952		20	298	298	298	25
26	SIGNS	2002	1,190		20	60	60	60	26
27	WALLCOVERING	2002	682		20	34	34	34	27
28	HANDSINK	2002	594		20	30	30	30	28
29	FOUNTAIN	2002	2,965		20	148	148	148	29
30	PUMP INSTALLATION	2002	2,950		20	148	148	148	30
31	MODULATORS	2002	1,890		20	95	95	95	31
32	ELECTRICAL FIXTURES	2002	1,360		20	68	68	68	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12D, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12E, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	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
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24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12F, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12G, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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23									23
24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12H, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	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
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20									20
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23									23
24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12I, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	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
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24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12I, Carried Forward		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	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
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24									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)		\$ 5,303,042	\$ 303,774		\$ 199,807	\$ (103,967)	\$ 1,546,480	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994	\$ 118,831	\$ 3,047	39	\$ 3,395	\$ 348	\$ 27,445	4
5			1994	141,423	3,626	39	4,041	415	32,662	5
6										6
7										7
8										8
Improvement Type**										
9	Allocation - KNR		1994	2,421		20	242	242	1,957	9
10	Allocation - KNR		1995	358	16	20	36	20	287	10
11	Allocation - KNR		1995	5,490	141	20	275	134	2,062	11
12	Allocation - KNR		1996	1,657	145	20	83	62	519	12
13	Allocation - KNR		1997	97	9	20	5	(4)	28	13
14	Allocation - KNR		1999	1,833	47	20	92	45	322	14
15	Allocation - KNR		2000	3,272	84	20	164	80	410	15
16	Allocation - Regency Rehab.		1994	2,881		20	288	288	2,329	16
17	Allocation - Regency Rehab.		1995	426	19	20	43	24	341	17
18	Allocation - Regency Rehab.		1995	6,511	167	20	326	159	2,442	18
19	Allocation - Regency Rehab.		1996	1,963	172	20	98	(74)	615	19
20	Allocation - Regency Rehab.		1997	115	10	20	6	(4)	33	20
21	Allocation - Regency Rehab.		1999	2,172	55	20	109	54	381	21
22	Allocation - Regency Rehab.		2000	1,803	46	20	37	(9)	226	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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57									57
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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)		\$ 291,253	\$ 7,584		\$ 9,240	\$ 1,780	\$ 72,059	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,323,176	\$	\$ 53,228	\$ 53,228	10	\$ 1,030,819	71
72	Current Year Purchases	78,587		7,378	7,378	10	7,378	72
73	Fully Depreciated Assets	5,689				10	5,689	73
74								74
75	TOTALS	\$ 1,407,452	\$	\$ 60,606	\$ 60,606		\$ 1,043,886	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 7,160,494	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 303,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 260,413	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,363)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,590,366	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	BUS - 1995	\$ 44,625	\$	\$ 44,625	86
87	1996 DODGE CARAVAN - 1996	36,356	3,636	22,119	87
88					88
89					89
90					90
91	TOTALS	\$ 80,981	\$ 3,636	\$ 66,744	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: N/A

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 29,864 Description: Helium Tanks \$506; Copiers \$15,708; Postage Meter \$709; Special Beds \$12,942

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* 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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 21,517		\$ 58,030						\$ 79,547	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,573						21,573	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 01	hrs	75,241		8,312						83,553	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy		# of prescripts										9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Exceptional Care Program												12
13	Other (specify): See Supplemental								49,436			49,436	13
14	TOTAL			\$ 96,758		\$ 87,915		\$ 49,436				\$ 234,109	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 87,265	\$ 87,265	1
2	Cash-Patient Deposits	29,593	29,593	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,729,295	1,729,295	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,131	17,131	6
7	Other Prepaid Expenses	1,590	1,590	7
8	Accounts Receivable (owners or related parties)	747,103	747,103	8
9	Other(specify): See Supplemental Schedule	309,047	309,047	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,921,024	\$ 2,921,024	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		760,000	13
14	Buildings, at Historical Cost		5,240,000	14
15	Leasehold Improvements, at Historical Cost	1,218,546	1,218,546	15
16	Equipment, at Historical Cost	1,486,477	1,486,477	16
17	Accumulated Depreciation (book methods)	(1,579,309)	(2,519,822)	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): See Supplemental Schedule	77,623	77,623	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,203,337	\$ 6,262,824	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,124,361	\$ 9,183,848	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,303,253	\$ 1,303,253	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,900	32,900	28
29	Short-Term Notes Payable	914,935	914,935	29
30	Accrued Salaries Payable	264,428	264,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,388	21,388	31
32	Accrued Real Estate Taxes(Sch.IX-B)	400,000	400,000	32
33	Accrued Interest Payable	33,387	33,387	33
34	Deferred Compensation	447,620	447,620	34
35	Federal and State Income Taxes	11,278	11,278	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,429,189	\$ 3,429,189	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,075,107	5,081,499	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,075,107	\$ 5,081,499	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,504,296	\$ 8,510,688	46
47	TOTAL EQUITY(page 18, line 24)	\$ (379,935)	\$ 673,160	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,124,361	\$ 9,183,848	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (83,758)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (83,758)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	738,823	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	(1,035,000)	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)	\$ (296,177)	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)	\$ (379,935)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,969,132	1
2	Discounts and Allowances for all Levels	(813,817)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,155,315	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	472,508	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 472,508	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	875	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,055	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,225	19
20	Radiology and X-Ray		20
21	Other Medical Services	110,389	21
22	Laundry	3,568	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 367,112	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	20,332	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,332	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		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)	\$ 12,015,267	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,850,044	31
32	Health Care	4,270,186	32
33	General Administration	2,871,722	33
B. Capital Expense			
34	Ownership	1,851,484	34
C. Ancillary Expense			
35	Special Cost Centers	268,758	35
36	Provider Participation Fee	164,250	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,276,444	40
41	Income before Income Taxes (line 30 minus line 40)**	738,823	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 738,823	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

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	1,921	2,162	\$ 77,852	\$ 36.01	1
2	Assistant Director of Nursing	3,531	3,894	106,722	27.41	2
3	Registered Nurses	50,367	54,134	1,166,461	21.55	3
4	Licensed Practical Nurses	16,422	17,867	331,035	18.53	4
5	Nurse Aides & Orderlies	167,798	179,558	1,746,111	9.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,439	2,888	96,758	33.50	7
8	Rehab/Therapy Aides	5,843	6,663	68,827	10.33	8
9	Activity Director	1,626	1,914	33,393	17.45	9
10	Activity Assistants	15,716	16,951	131,465	7.76	10
11	Social Service Workers	7,316	8,183	164,108	20.05	11
12	Dietician					12
13	Food Service Supervisor	1,996	2,231	54,617	24.48	13
14	Head Cook	5,638	6,261	74,760	11.94	14
15	Cook Helpers/Assistants	36,535	39,996	291,262	7.28	15
16	Dishwashers					16
17	Maintenance Workers	5,518	5,921	111,756	18.87	17
18	Housekeepers	33,661	36,389	291,959	8.02	18
19	Laundry	16,017	17,590	116,647	6.63	19
20	Administrator	1,790	2,118	137,310	64.83	20
21	Assistant Administrator	1,829	2,139	43,581	20.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,580	14,615	292,773	20.03	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) <u>See Supplemental</u>	2,111	2,269	34,649	15.27	33
34	TOTAL (lines 1 - 33)	391,654	423,743	\$ 5,372,046 *	\$ 12.68	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	516	\$ 21,681	01-03	35
36	Medical Director	Monthly	46,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	228	11,390	10-03	38
39	Pharmacist Consultant	Monthly	450	10-03	39
40	Physical Therapy Consultant	1	30	10a-03	40
41	Occupational Therapy Consultant	16	814	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,234	11-03	44
45	Social Service Consultant	Monthly	3,200	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	783	\$ 88,927		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,830	\$ 73,235	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,830	\$ 73,235		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Barbara Hecht	Administrator	None	\$ 137,310	Workers' Compensation Insurance	\$ 90,572	IDPH License Fee	\$	
Carol Eaton	Asst. Admin.	None	43,581	Unemployment Compensation Insurance	26,593	Advertising: Employee Recruitment	20,784	
				FICA Taxes	406,604	Health Care Worker Background Check	458	
				Employee Health Insurance	589,862	(Indicate # of checks performed <u>38</u>)		
				Employee Meals	52,195	Dues and Subscriptions/License & Fees	31,600	
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	111,727	
				Pension Expense	58,150	Allocated from KNR	70	
				Holiday Expense	3,673	Allocated from Regency Mgmt.	26	
						Allocated from Regency Rehab.	577	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 180,891					
B. Administrative - Other								
Description			Amount					
Regency Management Corp. - Mangement Fees			\$ 445,250					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 445,250					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Schmidt Salzman & Moran	Legal		\$ 19,379			\$	Out-of-State Travel	\$
Winston & Strawn	Legal		6,558					
Sugar, Friedberg & Felsenthal	Legal		617					
Medi-Com	Data Processing		204				In-State Travel	
Health Data Service	Data Processing		10,271					
Accu-Med	Data Processing		1,800					
Ivans	Data Processing		261					
Frost, Ruttenberg & Rothblatt	Accounting		50,281				Seminar Expense	2,304
Gates McDonald	UC Tax Rate Service		2,700					
See Attached			28,909					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 120,980	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,304

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number REGENCY HLTHCARE & REHAB CTRE

0022418

Report Period Beginning:

01/01/02

Ending:

12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC - \$17,100
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,718 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 164,250
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 52,195 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1
d. Have vehicle usage logs been maintained? N/A
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? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT