

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0022418

**Facility Name:** Regency Healthcare & Rehab Ctre

**Address:** 6631 Milwaukee Avenue Niles 60714  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (847) 647-7444 **Fax #** (847) 588-1330

**HFS ID Number:** 362871301002

**Date of Initial License for Current Owners:** 5/1/1976

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
<b>Paid Preparer</b>	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctr

# 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,500</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>43,502</u>	<u>16,784</u>	<u>12,218</u>	<u>72,504</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,502</u>	<u>16,784</u>	<u>12,218</u>	<u>72,504</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.21%

D. How many bed-hold days during this year were paid by the Department?

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)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 5/13/1976

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 4/30/1981 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 87 and days of care provided 12,218

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	482,802	54,247	41,964	579,013		579,013		579,013		1
2	Food Purchase		480,755		480,755	(68,620)	412,135	(1,108)	411,027		2
3	Housekeeping	301,440	46,103		347,543		347,543		347,543		3
4	Laundry	134,323	22,994	300	157,617		157,617		157,617		4
5	Heat and Other Utilities			262,016	262,016		262,016	4,747	266,763		5
6	Maintenance	131,343	39,845	91,768	262,956		262,956	764	263,720		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,049,908</b>	<b>643,944</b>	<b>396,048</b>	<b>2,089,900</b>	<b>(68,620)</b>	<b>2,021,280</b>	<b>4,403</b>	<b>2,025,683</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			45,304	45,304		45,304		45,304		9
10	Nursing and Medical Records	3,643,484	134,883	12,855	3,791,222		3,791,222		3,791,222		10
10a	Therapy	28,977	265	3,000	32,242		32,242	974	33,216		10a
11	Activities	188,199	10,673	2,088	200,960		200,960		200,960		11
12	Social Services	175,773			175,773		175,773		175,773		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>4,036,433</b>	<b>145,821</b>	<b>63,247</b>	<b>4,245,501</b>		<b>4,245,501</b>	<b>974</b>	<b>4,246,475</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	186,234		327,075	513,309		513,309	(78,729)	434,580		17
18	Directors Fees										18
19	Professional Services			102,250	102,250		102,250	7,316	109,566		19
20	Dues, Fees, Subscriptions & Promotions			73,860	73,860		73,860	(37,462)	36,398		20
21	Clerical & General Office Expenses	385,800	57,372	490,691	933,863		933,863	(443,439)	490,424		21
22	Employee Benefits & Payroll Taxes			1,099,698	1,099,698	68,620	1,168,318		1,168,318		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,156	5,156		5,156		5,156		24
25	Other Admin. Staff Transportation			1,322	1,322		1,322		1,322		25
26	Insurance-Prop.Liab.Malpractice			330,395	330,395		330,395	2,927	333,322		26
27	Other (specify):*							16,808	16,808		27
28	<b>TOTAL General Administration</b>	<b>572,034</b>	<b>57,372</b>	<b>2,430,447</b>	<b>3,059,853</b>	<b>68,620</b>	<b>3,128,473</b>	<b>(532,579)</b>	<b>2,595,894</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,658,375</b>	<b>847,137</b>	<b>2,889,742</b>	<b>9,395,254</b>		<b>9,395,254</b>	<b>(527,203)</b>	<b>8,868,051</b>		<b>29</b>

\*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.

Facility Name & ID Number Regency Healthcare & Rehab Ctre #0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			162,002	162,002		162,002	207,988	369,990		30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)			31
32	Interest			127,340	127,340		127,340	135,466	262,806		32
33	Real Estate Taxes			520,619	520,619		520,619	19,814	540,433		33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,080,000)			34
35	Rent-Equipment & Vehicles			27,235	27,235		27,235		27,235		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,927,900	1,927,900		1,927,900	(727,436)	1,200,464		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	141,114	284,635	785,454	1,211,203		1,211,203	(1,538)	1,209,665		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):*	103,787		3,267	107,054		107,054	(107,054)			43
44	<b>TOTAL Special Cost Centers</b>	244,901	284,635	952,971	1,482,507		1,482,507	(108,592)	1,373,915		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,903,276	1,131,772	5,770,613	12,805,661		12,805,661	(1,363,231)	11,442,430		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	67,911	30		9
10	Interest and Other Investment Income	(78,785)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,108)	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	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(415,287)	21		24
25	Fund Raising, Advertising and Promotional	(37,479)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,700)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(143,442)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (616,990)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(746,241)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (746,241)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,363,231)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line
1 Capitalized REIM	\$ 2,820	06
2 Marketing Salaries & Bonus	(163,797)	43
3 Bank Charges	(13,589)	23
4 Amortization	(16,784)	33
5 Non-Cash Depreciation	(1,776)	80
6 Marketing Travel	(3,267)	43
7 Non-Allowable Expense	(7,500)	23
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101 Total	(143,442)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Regency Healthcare &amp; Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(1,108)											(1,108)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,109	2,638								4,747	5
6	Maintenance	(2,820)		1,561	2,023								764	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(3,928)</b>		<b>3,670</b>	<b>4,661</b>								<b>4,403</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy				974								974	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>				<b>974</b>								<b>974</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative					(78,729)							(78,729)	17
18	Directors Fees													18
19	Professional Services			532	2,384	4,400							7,316	19
20	Fees, Subscriptions & Promotions	(37,579)			17	100							(37,462)	20
21	Clerical & General Office Expenses	(445,076)			1,637								(443,439)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			601	2,326								2,927	26
27	Other (specify):*					16,808							16,808	27
28	<b>TOTAL General Administration</b>	<b>(482,655)</b>		<b>1,133</b>	<b>6,364</b>	<b>(57,421)</b>							<b>(532,579)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(486,583)</b>		<b>4,803</b>	<b>11,999</b>	<b>(57,421)</b>							<b>(527,203)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Healthcare & Rehab Ctr # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	66,136	134,359	3,354	4,139								207,988	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(78,785)	191,726	9,827	12,698								135,466	32
33	Real Estate Taxes			8,801	11,013								19,814	33
34	Rent-Facility & Grounds		(1,032,000)	(48,000)									(1,080,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(23,353)</b>	<b>(705,915)</b>	<b>(26,018)</b>	<b>27,850</b>								<b>(727,436)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(1,538)								(1,538)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(107,054)											(107,054)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(107,054)</b>			<b>(1,538)</b>								<b>(108,592)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(616,990)</b>	<b>(705,915)</b>	<b>(21,215)</b>	<b>38,310</b>	<b>(57,421)</b>							<b>(1,363,231)</b>	<b>45</b>

**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 Company
Benjamin Rogow	33.33			KNR Partnership	Niles	Building Company
Lother Kahn	33.33			Regency Rehab	Niles	Therapy Company
				Regency Building	Niles	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,032,000	Regency Building	100.00%	\$	\$ (1,032,000)	1
2	V	32 Interest				191,726	191,726	2
3	V	30 Depreciatin				134,359	134,359	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			\$ 326,085	\$ * (705,915)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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%	\$ 2,109	\$ 2,109	15
16	V	6 REPAIRS AND MAINT.		KNR ENTERPRISES		1,561	1,561	16
17	V	19 PROFESSIONAL FEES		KNR ENTERPRISES		532	532	17
18	V	20 DUES AND SUBS.		KNR ENTERPRISES				18
19	V	21 CLERICAL		KNR ENTERPRISES				19
20	V	26 INSURANCE		KNR ENTERPRISES		601	601	20
21	V	30 DEPRECIATION		KNR ENTERPRISES		3,047	3,047	21
22	V	32 INTEREST EXPENSE		KNR ENTERPRISES		9,827	9,827	22
23	V	33 REAL ESTATE TAXES		KNR ENTERPRISES		8,801	8,801	23
24	V			KNR ENTERPRISES				24
25	V							25
26	V	34 RENT	48,000	KNR ENTERPRISES			(48,000)	26
27	V							27
28	V							28
29	V	30 DEPRECIATION		KNR ENTERPRISES		307	307	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		\$ 48,000			\$ 26,785	\$ * (21,215)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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%	\$ 2,638	\$ 2,638	15
16	V	6 REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		2,023	2,023	16
17	V	10 NURSING		REGENCY REHABILITATION SERVICES, INC.				17
18	V	10A THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		974	974	18
19	V	14 PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.				19
20	V	19 PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		2,384	2,384	20
21	V	20 DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		17	17	21
22	V	21 CLERICAL		REGENCY REHABILITATION SERVICES, INC.		1,637	1,637	22
23	V	26 INSURANCE		REGENCY REHABILITATION SERVICES, INC.		2,326	2,326	23
24	V	30 DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		4,139	4,139	24
25	V	32 INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		12,698	12,698	25
26	V	33 REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		11,013	11,013	26
27	V	39 THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		294	294	27
28	V							28
29	V							29
30	V							30
31	V	39 PHYSICAL THERAPY	1,832	REGENCY REHABILITATION SERVICES, INC.			(1,832)	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,832			\$ 40,142	\$ * 38,310	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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%	\$ 4,400	\$ 4,400	15
16	V	20 DUES, SUBSCRIPTIONS		REGENCY MANAGEMENT CORP.		100	100	16
17	V			REGENCY MANAGEMENT CORP.				17
18	V							18
19	V	17 MANAGEMENT FEES	327,075	REGENCY MANAGEMENT CORP.			(327,075)	19
20	V							20
21	V							21
22	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		91,650	91,650	22
23	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		6,203	6,203	23
24	V							24
25	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		83,571	83,571	25
26	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,656	5,656	26
27	V							27
28	V	17 ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		73,125	73,125	28
29	V	27 EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		4,949	4,949	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		\$ 327,075			\$ 269,654	\$ * (57,421)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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 Nieman	Secretary	Administrative	33.34	None	10.00	25.00%	Mgmt Fee	\$ 73,125	17-7	1
2	Benjamin Rogow	President	Administrative	33.33	None	47.00	78.33%	Mgmt Fee	91,650	17-7	2
3	Lothar Kahn	Treasurer	Administrative	33.33	None	15.00	37.50%	Mgmt Fee	83,571	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 248,346		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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 22,778	\$ 616	\$ 2,109	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	16,862	616	1,561	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	5,750	616	532	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4		616		4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4		616		5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	6,491	616	601	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	32,913	616	3,047	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	106,152	616	9,827	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	95,066	616	8,801	9
10									10
11									11
12									12
13									13
14									14
15	30	DEPRECIATION	DIRECT ALLOCATION		4	3,086		307	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 289,098	\$	\$ 26,785	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	2,355	3	\$ 3,392	\$ 1,832	\$ 2,638	1	
2	6	REPAIRS AND MAINT.	THERAPY INCOME	2,355	3	2,601	1,832	2,023	2	
3	10	NURSING	THERAPY INCOME	2,355	3		1,832		3	
4	10A	THERAPY CONSULTANTS	THERAPY INCOME	2,355	3	1,252	1,832	974	4	
5	14	PROGRAM TRANSPORTATION	THERAPY INCOME	2,355	3		1,832		5	
6	19	PROFESSIONAL FEES	THERAPY INCOME	2,355	3	3,065	1,832	2,384	6	
7	20	DUES AND SUBS.	THERAPY INCOME	2,355	3	21	1,832	17	7	
8	21	CLERICAL	THERAPY INCOME	2,355	3	2,104	1,832	1,637	8	
9	26	INSURANCE	THERAPY INCOME	2,355	3	2,990	1,832	2,326	9	
10	30	DEPRECIATION	THERAPY INCOME	2,355	3	5,321	1,832	4,139	10	
11	32	INTEREST EXPENSE	THERAPY INCOME	2,355	3	16,325	1,832	12,698	11	
12	33	REAL ESTATE TAXES	THERAPY INCOME	2,355	3	14,159	1,832	11,013	12	
13	39	THERAPY SALARY & BENEFIT	THERAPY INCOME	2,355	3	378	256	1,832	294	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					\$ 51,608	\$ 256	\$ 40,142	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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.	326,075	1	\$ 4,400	\$ 326,075	\$ 4,400	1	
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	326,075	1	100	326,075	100	2	
3									3	
4									4	
5									5	
6									6	
7									7	
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	117,000	117,000	47	91,650	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	7,919	47	6,203	9	
10									10	
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	117,000	117,000	15	83,571	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	7,919	15	5,656	12	
13									13	
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	117,000	117,000	10	73,125	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	7,919	10	4,949	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 379,257	\$ 351,000	\$ 269,654	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Northern Life Insurance		X	Mortgage	\$64,500.00	3/1/95	\$ 6,000,000	\$ 1,597,062	3/1/10	10.0000	\$ 191,726	1				
2												2				
3												3				
4												4				
5	See Supplemental Schedule											5				
<b>Working Capital</b>																
6	JP Morgan Chase		X	Line of Credit				1,700,000			127,340	6				
7	MB Financial		X	Line of Credit				519,800				7				
8	See Supplemental Schedule							160,496			22,525	8				
9	<b>TOTAL Facility Related</b>				\$64,500.00		\$ 6,000,000	\$ 3,977,358			\$ 341,591	9				
<b>B. Non-Facility Related*</b>																
10	Interest Income										(78,785)	10				
11												11				
12												12				
13	See Supplemental Schedule											13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(78,785)	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 6,000,000	\$ 3,977,358			\$ 262,806	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	<b>TOTAL Long-Term</b>											7
	<b>Working Capital</b>											
8	Regency at Home Health	X					\$	\$ 160,496			\$	8
9	Allocated - KNR Enterprises		X								9,827	9
10	Allocated - Regency Rehab.		X								12,698	10
11												11
12												12
13												13
14	<b>TOTAL Working Capital</b>							160,496			22,525	14
	<b>B. Non-Facility Related*</b>											
15							\$	\$			\$	15
16												16
17												17
18												18
19												19
20	<b>TOTAL Non-Facility Related</b>											20

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>432,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>484,506</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>52,506</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>487,927</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>540,433</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>394,414</u>	8			
2003	<u>424,813</u>	9			
2004	<u>422,424</u>	10			
2005	<u>438,752</u>	11			
2006	<u>464,692</u>	12			
<b>2007 Accrual = 2006 Tax + 5% (464,692 x 1.05 = \$487,927)</b>					
<b>Allocated from KNR Enterprises \$19,814</b>					
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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 Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Regency Healthcare & 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-31-401-017-0000</u>	<u>Long Term Care Property</u>	<u>\$ 4,257.39</u>	<u>\$ 4,257.39</u>
2. <u>10-31-401-018-0000</u>	<u>Long Term Care Property</u>	<u>\$ 102,075.47</u>	<u>\$ 102,075.47</u>
3. <u>10-31-401-019-0000</u>	<u>Long Term Care Property</u>	<u>\$ 128,141.98</u>	<u>\$ 128,141.98</u>
4. <u>10-31-401-020-0000</u>	<u>Long Term Care Property</u>	<u>\$ 128,141.98</u>	<u>\$ 128,141.98</u>
5. <u>10-31-401-021-0000</u>	<u>Long Term Care Property</u>	<u>\$ 102,075.35</u>	<u>\$ 102,075.35</u>
6. <u>See Attached</u>	<u>See Attached</u>	<u>\$ 86,373.84</u>	<u>\$ 18,001.69</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 551,066.01</u>	<u>\$ 482,693.86</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? X 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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**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 Healthcare & 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.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
<b>TOTALS</b>		\$	\$

**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 Healthcare & Rehab Ctre

# 0022418 Report Period Beginning:

01/01/07 Ending:

12/31/07

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

Regency At Home Services, Ltd. - Home Health Agency - Separate Building

Regency At-Home Care Services, 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:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1987	2,440		20			1,502	9
10	Various			1995	55,899		20	2,796	2,796	35,184	10
11	Various			1996	143,243		20	7,167	7,167	81,835	11
12	Various			1997	109,626		20	5,484	5,484	58,474	12
13	Various			1998	546,842		20	27,342	27,342	252,400	13
14	Various			1999	142,449		20	7,123	7,123	61,113	14
15	Various			2000	98,866		20	4,945	4,945	38,567	15
16	Various			2001	112,212		20	5,613	5,613	37,162	16
17	Various			2002	91,837		20	9,183	9,183	52,030	17
18	Various			2003	57,110		20	5,712	5,712	26,210	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

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		3,708,375	134,359		123,613	(10,746)	1,822,091	67
68		302,420	7,493		9,398	1,905	120,584	68
69			160,227			(160,227)		69
70		\$ 5,371,319	\$ 302,079		\$ 208,376	\$ (93,703)	\$ 2,587,152	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Regency Healthcare &amp; Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,371,319	\$ 302,079		\$ 208,376	\$ (93,703)	\$ 2,587,152	1
2	Electrical Improv	2004	15,618		20	1,562	1,562	5,466	2
3	Nurse Call System	2004	18,975		20	1,898	1,898	6,325	3
4	Window Drapes	2004	39,608		20	4,375	4,375	15,311	4
5	Repair Tile	2004	1,812		20	181	181	680	5
6	Phase Failure System	2005	23,400		20	2,340	2,340	7,020	6
7	Handicap Access Door	2005	6,100		20	610	610	1,728	7
8	Elevator Equip	2005	4,379		20	876	876	2,262	8
9	Hot Water Boiler	2005	4,847		20	242	242	687	9
10	Kitchen Equipment	2006	1,850		20	370	370	432	10
11	Elevator Improv	2006	94,880		20	9,488	9,488	18,976	11
12	Elevator Improv	2006	36,940		20	3,694	3,694	7,388	12
13	Elevator Improv	2006	1,860		20	186	186	357	13
14	Smoke Detectors	2006	30,000		20	3,000	3,000	5,500	14
15	Elevator Improv	2006	48,000		20	4,800	4,800	8,800	15
16	Elevator Improv	2006	10,928		20	1,093	1,093	2,003	16
17	Tile, Paint Walls, Wallpaper, Bathroom Repair	2006	39,331		20	3,933	3,933	6,883	17
18	Elevator Improv	2006	5,767		20	577	577	961	18
19	Door Locks & Hardware	2006	6,996		20	700	700	1,108	19
20	Exit Signs	2006	1,575		20	158	158	249	20
21	New Circulating Pump In Chiller Room	2006	915		20	92	92	145	21
22	Smoke Detectors	2006	2,000		20	200	200	317	22
23	Wiring For Two New Sprinkler Valves	2006	3,817		20	382	382	509	23
24	Damper Motors	2006	1,698		20	170	170	212	24
25	Submersible Pumps	2006	7,408		20	741	741	926	25
26	Smoke Duct Dampers	2006	6,977		20	698	698	814	26
27	Electrical Work	2006	24,290		20	2,429	2,429	2,631	27
28	Resident Room Tiling, Flooring	2006	23,987		20	2,399	2,399	3,198	28
29	Lease Improv	2006	4,462		20	446	446	595	29
30	Elevator Improv	2006	1,000		20	100	100	183	30
31	Room Remodel - Drywall And Doors*	2006	7,850		20	393	393	458	31
32	Remodel 2 Bathrooms - Floor And Wall Tile*	2006	5,400		20	270	270	270	32
33	Oak Flooring*	2006	2,584		20	129	129	140	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,856,573	\$ 302,079		\$ 256,908	\$ (45,171)	\$ 2,689,686	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,856,573	\$ 302,079		\$ 256,908	\$ (45,171)	\$ 2,689,686	1
2	Lower Level Improvement*	2007	5,687		20	1,722	1,722	1,722	2
3	Flooring Reclassified Below*	2007			20	1,642	1,642	1,642	3
4	Bathroom Renovations*	2007	14,967		20	2,831	2,831	2,831	4
5	Wall Coverings/Bathroom Improvements*	2007	47,971		20	2,606	2,606	2,606	5
6	Basement Level Hallway - Tile, Drywall And Wall Improv	2007	4,850		20	243	243	243	6
7	Basement Level Hallway - Tile And Baseboard	2007	4,400		20	220	220	220	7
8	Outlets And Electrical Work	2007	3,600		20	180	180	180	8
9	Marble Tile, Molding, Chair Railing	2007	11,350		20	568	568	568	9
10	Drywall, Door, Countertops, Sink And Ceramic Tile	2007	11,850		20	593	593	593	10
11	Flooring	2007	15,303		20	765	765	765	11
12	Wallcovering	2007	4,145		20	207	207	207	12
13	Bathroom Repair,Paint Walls,New Outlet-Rooms 417,419,420	2007	4,978		20	249	249	249	13
14	Bathroom Repair, Paint Walls, New Outlet-Rooms 414 & 421	2007	3,052		20	153	153	153	14
15	Bathroom Floor And Wall Tile	2007	11,411		20	571	571	571	15
16	Bathroom Repair, Paint Walls, New Outlet-Rooms 416 & 418	2007	3,452		20	173	173	173	16
17	Bathroom Repair, Paint Walls, New Outlet-Rooms 415 & 413	2007	3,602		20	180	180	180	17
18	Bathroom Repair, Paint Walls, New Outlet-Rooms 422 & 423	2007	3,052		20	153	153	153	18
19	New Gfi Outlets	2007	6,600		20	330	330	330	19
20	Bathroom Repair,Paint Walls,New Outlet-Rooms 403,404,407	2007	4,978		20	249	249	249	20
21	Doors And Laminate Panels	2007	2,820		20	141	141	141	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12F, Carried Forward</b>	\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1	
2								2	
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4								4	
5								5	
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28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1
2									2
3									3
4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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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)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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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)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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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)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,024,641	\$ 302,079		\$ 270,681	\$ (31,398)	\$ 2,703,459	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1981	1976	\$ 3,708,375	\$ 134,359	30	\$ 123,613	\$ (10,746)	\$ 1,822,091	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
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											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	3,708,375	\$	134,359	\$	123,613	\$	(10,746)	\$	1,822,091	70

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	
	FOR OHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* <sup>*</sup>	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	KNR Enterprises	1994	1994	\$ 118,831	\$ 3,047	35	\$ 3,395	\$ 348	\$ 44,421	4
5	Regency Rehabilitation	1994	1994	148,698	3,813	35	4,248	435	55,586	5
6										6
7										7
8										8
Improvement Type**										
9	KNR Enterprises		1994	2,421		20			2,421	9
10	KNR Enterprises		1995	358		20			358	10
11	KNR Enterprises		1995	5,490	141	20	275	134	3,434	11
12	KNR Enterprises		1996	1,657		20	83	83	933	12
13	KNR Enterprises		1997	97		20	5	5	52	13
14	KNR Enterprises		1999	1,833	47	20	92	45	780	14
15	KNR Enterprises		2000	3,272	84	20	164	80	1,228	15
16	KNR Enterprises		2003	1,369	35	20	68	33	314	16
17										17
18	Regency Rehabilitation		1994	3,029		20	278	278	3,029	18
19	Regency Rehabilitation		1995	448		20	44	44	448	19
20	Regency Rehabilitation		1995	6,846	176	20	342	166	4,279	20
21	Regency Rehabilitation		1996	2,064		20	103	103	1,162	21
22	Regency Rehabilitation		1997	121		20	6	6	65	22
23	Regency Rehabilitation		1999	2,284	58	20	114	56	972	23
24	Regency Rehabilitation		2000	1,896	48	20	95	47	711	24
25	Regency Rehabilitation		2003	1,706	44	20	86	42	391	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	302,420	\$	7,493	\$	9,398	\$	1,905	\$	120,584	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 Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 1,039,563	\$	\$ 90,597	\$ 90,597	10	\$ 799,891	71
72	Current Year Purchases	93,268		8,712	8,712	10	8,712	72
73	Fully Depreciated Assets	619,271				10	619,271	73
74								74
75	TOTALS	\$ 1,752,102	\$	\$ 99,309	\$ 99,309		\$ 1,427,874	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)	\$ 8,226,743	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 302,079	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 369,990	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,911	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,131,333	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	\$	\$	86
87	1996 DODGE CARAVAN - 1996	36,356	1,775	25,643	87
88					88
89					89
90					90
91	TOTALS	\$ 80,981	\$ 1,775	\$ 25,643	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Original Lease Date	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	<b>TOTAL</b>				\$			7

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 27,235 Description: See Attached Schedule

(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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs 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 CNA _____</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 CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 204,225	\$		\$ 204,225	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	5,884		119,405			125,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	135,230		263,010			398,240	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			198,814	148,048		346,862	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>						136,587		136,587	13
14	<b>TOTAL</b>			\$ 141,114		\$ 785,454	\$ 284,635		\$ 1,211,203	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre# 0022418Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (337,546)	\$ (337,546)	1
2	Cash-Patient Deposits	45,541	45,541	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,074,267	2,074,267	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,064	22,064	6
7	Other Prepaid Expenses	1,592	1,592	7
8	Accounts Receivable (owners or related parties)	1,376,532	1,376,532	8
9	Other(specify): <u>See Attached Schedule</u>	321,233	321,233	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,503,683	\$ 3,503,683	10
	<b>B. Long-Term Assets</b>			
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	1,873,661	1,873,661	15
16	Equipment, at Historical Cost	1,881,799	1,881,799	16
17	Accumulated Depreciation (book methods)	(2,293,352)	(3,905,660)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	24,103	24,103	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,486,211	\$ 5,873,903	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,989,894	\$ 9,377,586	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,580,431	\$ 2,580,431	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,374	46,374	28
29	Short-Term Notes Payable	2,380,296	2,380,296	29
30	Accrued Salaries Payable	151,924	151,924	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,532	21,532	31
32	Accrued Real Estate Taxes(Sch.IX-B)	487,927	487,927	32
33	Accrued Interest Payable	12,926	12,926	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,800	8,800	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	525	525	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,690,735	\$ 5,690,735	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,597,062	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 1,597,062	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,690,735	\$ 7,287,797	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (700,841)	\$ 2,089,789	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,989,894	\$ 9,377,586	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (351,832)	1
2	Restatements (describe):		2
3	<b>Retained Earnings Adjustment</b>	(92,945)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (444,777)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	433,936	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	(690,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (256,064)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (700,841)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre

# 0022418

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,918,647	1
2	Discounts and Allowances for all Levels	(1,998,617)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,920,030	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,446,207	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,446,207	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	750	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,297	19
20	Radiology and X-Ray		20
21	Other Medical Services	620,112	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 651,159	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	78,785	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 78,785	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	143,416	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 143,416	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,239,597	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,089,900	31
32	Health Care	4,245,501	32
33	General Administration	3,059,853	33
<b>B. Capital Expense</b>			
34	Ownership	1,927,900	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,318,257	35
36	Provider Participation Fee	164,250	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,805,661	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	433,936	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 433,936	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 Healthcare & Rehab Ctre

# 0022418

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,656	2,941	\$ 114,992	\$ 39.10	1
2	Assistant Director of Nursing	1,817	2,272	80,711	35.52	2
3	Registered Nurses	43,622	47,409	1,247,407	26.31	3
4	Licensed Practical Nurses	20,395	22,097	479,030	21.68	4
5	CNAs & Orderlies	153,360	165,945	1,721,344	10.37	5
6	CNA Trainees					6
7	Licensed Therapist	3,769	4,132	141,114	34.15	7
8	Rehab/Therapy Aides	2,357	2,579	28,977	11.24	8
9	Activity Director	2,129	2,204	33,908	15.38	9
10	Activity Assistants	14,360	15,407	154,291	10.01	10
11	Social Service Workers	8,979	10,135	175,773	17.34	11
12	Dietician					12
13	Food Service Supervisor	4,916	5,639	100,175	17.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	46,591	50,788	382,627	7.53	15
16	Dishwashers					16
17	Maintenance Workers	5,681	6,002	131,343	21.88	17
18	Housekeepers	30,441	33,155	301,440	9.09	18
19	Laundry	16,415	17,952	134,323	7.48	19
20	Administrator	1,453	1,828	125,649	68.74	20
21	Assistant Administrator	2,356	2,730	60,585	22.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,528	20,312	385,800	18.99	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>	4,986	5,467	103,787	18.98	33
34	TOTAL (lines 1 - 33)	384,811	418,994	\$ 5,903,276 *	\$ 14.09	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	1,000	\$ 41,964	01-03	35
36	Medical Director	monthly	45,304	09-03	36
37	Medical Records Consultant	monthly	3,520	10-03	37
38	Nurse Consultant	76	3,775	10-03	38
39	Pharmacist Consultant	monthly	2,060	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,088	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Nurse Consultant</u>	monthly	3,500	10-03	47
48	<u>Rehab Consultant</u>	monthly	3,000	10A-03	48
49	TOTAL (lines 35 - 48)	1,118	\$ 105,211		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Regency Healthcare & Rehab Ctre

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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. ICLTC \$16,500
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,464 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 68,620 Has any meal income been offset against related costs? No 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% ln 14  
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT