



Facility Name & ID Number Regency Rehabilitation Center

# 0049841 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	57,341	15,239	15,186	87,766	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,341	15,239	15,186	87,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.15%

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 01/01/08

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/08 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 300 and days of care provided 12,557

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Regency Rehabilitation Center # 0049841 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	467,488	68,494	54,931	590,913		590,913	(23,972)	566,941		1
2	Food Purchase		553,992		553,992		553,992	(1,891)	552,101		2
3	Housekeeping	297,629	61,818		359,447		359,447	(2,119)	357,328		3
4	Laundry	149,249	29,977		179,226		179,226	(421)	178,805		4
5	Heat and Other Utilities			229,964	229,964		229,964	9,810	239,774		5
6	Maintenance	100,567	55,823	308,631	465,021		465,021	(87,957)	377,064		6
7	Other (specify):*							5,619	5,619		7
8	<b>TOTAL General Services</b>	<b>1,014,933</b>	<b>770,104</b>	<b>593,526</b>	<b>2,378,563</b>		<b>2,378,563</b>	<b>(100,930)</b>	<b>2,277,633</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			52,800	52,800		52,800		52,800		9
10	Nursing and Medical Records	4,031,852	263,551	83,120	4,378,523		4,378,523	(51,396)	4,327,127		10
10a	Therapy	126,725		32,843	159,568		159,568	(24,186)	135,382		10a
11	Activities	248,185	14,712	8,572	271,469		271,469		271,469		11
12	Social Services	220,384		2,103	222,487		222,487		222,487		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,695	5,695		15
16	<b>TOTAL Health Care and Programs</b>	<b>4,627,146</b>	<b>278,263</b>	<b>179,438</b>	<b>5,084,847</b>		<b>5,084,847</b>	<b>(69,887)</b>	<b>5,014,960</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	190,138		945,651	1,135,789		1,135,789	(786,445)	349,344		17
18	Directors Fees										18
19	Professional Services			255,872	255,872	(11,763)	244,109	(172,630)	71,479		19
20	Dues, Fees, Subscriptions & Promotions			125,673	125,673		125,673	(62,783)	62,890		20
21	Clerical & General Office Expenses	141,647	51,438	818,545	1,011,630		1,011,630	(550,556)	461,074		21
22	Employee Benefits & Payroll Taxes			1,154,429	1,154,429		1,154,429		1,154,429		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,380	3,380		3,380	417	3,797		24
25	Other Admin. Staff Transportation			4,445	4,445		4,445	12,294	16,739		25
26	Insurance-Prop.Liab.Malpractice			211,367	211,367		211,367	1,634	213,001		26
27	Other (specify):*							54,287	54,287		27
28	<b>TOTAL General Administration</b>	<b>331,785</b>	<b>51,438</b>	<b>3,519,362</b>	<b>3,902,585</b>	<b>(11,763)</b>	<b>3,890,822</b>	<b>(1,503,782)</b>	<b>2,387,040</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,973,864</b>	<b>1,099,805</b>	<b>4,292,326</b>	<b>11,365,995</b>	<b>(11,763)</b>	<b>11,354,232</b>	<b>(1,674,599)</b>	<b>9,679,633</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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38,154	38,154		38,154	346,060	384,214			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,434	80,434		80,434	(67,450)	12,984			32
33	Real Estate Taxes			576,000	576,000	11,763	587,763	41,517	629,280			33
34	Rent-Facility & Grounds			1,548,000	1,548,000		1,548,000	(51,690)	1,496,310			34
35	Rent-Equipment & Vehicles			6,355	6,355		6,355	12,153	18,508			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,248,943	2,248,943	11,763	2,260,706	280,590	2,541,296			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		643,921	1,118,752	1,762,673		1,762,673		1,762,673			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):*	163,085		18,000	181,085		181,085	(181,085)				43
44	<b>TOTAL Special Cost Centers</b>	163,085	643,921	1,301,002	2,108,008		2,108,008	(181,085)	1,926,923			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,136,949	1,743,726	7,842,271	15,722,946		15,722,946	(1,575,094)	14,147,852			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	(933)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,058)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	314,928	30		9
10	Interest and Other Investment Income	(43,736)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(958)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(625,824)	21		24
25	Fund Raising, Advertising and Promotional	(53,925)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(200)	20		28
29	Other-Attach Schedule	(276,111)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (713,816)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(861,278)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (861,278)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,575,094)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Regency Rehabilitation CenterID# 0049841Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Telephone Revenue	\$ (13,090)	21	1
2	Marketing Salary	(163,085)	43	2
3	Theft Damage	(787)	21	3
4	Bank Fees	(7,477)	21	4
5	Capitalized R&M	(54,361)	06	5
6	COPE Dues	(8,609)	20	6
7	Collection Fees	(428)	20	7
8	2010 Seminars	(95)	24	8
9	Collections	(1,229)	21	9
10	Non-allowable Legal	(1,110)	19	10
11	Non-allowable Legal S.I.R.	(1,000)	19	11
12	Non-allowable Marketing	(18,000)	43	12
13	Non-allowable Travel	(2,390)	06	13
14	Non-Care Depreciation	(534)	30	14
15	Licenses and Permits- Bldg Co.	(309)	20	15
16	Office Expense- Bldg Co	(82)	21	16
17	Professional Fees- Bldg Co.	(3,500)	19	17
18	State Income Tax- Bldg Co.	(25)	21	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(276,111)		49

Regency Rehabilitation Center

ID# 0049841

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Rehabilitation Center# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(23,972)								(23,972)	1
2	Food Purchase	(1,891)											(1,891)	2
3	Housekeeping					(2,119)							(2,119)	3
4	Laundry					(421)							(421)	4
5	Heat and Other Utilities		6,773		3,037								9,810	5
6	Maintenance	(65,809)	2,105	(17,414)	(6,839)								(87,957)	6
7	Other (specify):*			1,204	4,415								5,619	7
8	<b>TOTAL General Services</b>	<b>(67,700)</b>	<b>8,878</b>	<b>(16,210)</b>	<b>(23,359)</b>	<b>(2,539)</b>							<b>(100,930)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(45,307)	9,654	(15,743)							(51,396)	10
10a	Therapy				(24,186)								(24,186)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,940	2,755								5,695	15
16	<b>TOTAL Health Care and Programs</b>			<b>(42,367)</b>	<b>(11,777)</b>	<b>(15,743)</b>							<b>(69,887)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(895,989)	109,544								(786,445)	17
18	Directors Fees													18
19	Professional Services	(5,610)	3,500	(190,063)	19,543								(172,630)	19
20	Fees, Subscriptions & Promotions	(63,471)	309	379									(62,783)	20
21	Clerical & General Office Expenses	(666,514)	107	115,763	88								(550,556)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(95)		512									417	24
25	Other Admin. Staff Transportation			12,294									12,294	25
26	Insurance-Prop.Liab.Malpractice			1,454	180								1,634	26
27	Other (specify):*			31,777	22,510								54,287	27
28	<b>TOTAL General Administration</b>	<b>(735,690)</b>	<b>3,916</b>	<b>(923,873)</b>	<b>151,865</b>								<b>(1,503,782)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(803,389)</b>	<b>12,794</b>	<b>(982,450)</b>	<b>116,729</b>	<b>(18,283)</b>							<b>(1,674,599)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	314,394	17,119		14,547								346,060	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(43,736)	(814)	(32,413)	9,513								(67,450)	32
33	Real Estate Taxes		32,415		9,102								41,517	33
34	Rent-Facility & Grounds		(51,690)										(51,690)	34
35	Rent-Equipment & Vehicles			12,153									12,153	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>270,658</b>	<b>(2,970)</b>	<b>(20,260)</b>	<b>33,162</b>								<b>280,590</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(181,085)											(181,085)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(181,085)</b>											<b>(181,085)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(713,816)	9,824	(1,002,710)	149,891	(18,283)							(1,575,094)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				6631 Milwaukee, LLC		Building Co.
				6625 Milwaukee, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,539,448	6631 Milwaukee, LLC		\$ 1,496,310	\$ (43,138)	1
2	V	33 Rental Income- Taxes	576,000	6631 Milwaukee, LLC		588,426	12,426	2
3	V	30 Depreciation Exp- Facility		6631 Milwaukee, LLC		17,119	17,119	3
4	V	32 Interest Income	814	6631 Milwaukee, LLC			(814)	4
5	V	20 Licenses and Permits		6631 Milwaukee, LLC		309	309	5
6	V	21 Office Expense		6631 Milwaukee, LLC		82	82	6
7	V	19 Professional Fees		6631 Milwaukee, LLC		3,500	3,500	7
8	V	5 Utilities		6625 Milwaukee, LLC		6,773	6,773	8
9	V	34 Rent	48,000	6625 Milwaukee, LLC		39,448	(8,552)	9
10	V	6 Elevator Maintainence		6625 Milwaukee, LLC		1,734	1,734	10
11	V	6 Exterminator		6625 Milwaukee, LLC		371	371	11
12	V	33 Real Estate	511	6625 Milwaukee, LLC		20,500	19,989	12
13	V	21 State Income Tax				25	25	13
14	Total		\$ 2,164,773			\$ 2,174,597	\$ *	9,824 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 32,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 14,986	\$ (17,414)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,204	1,204
17	V	10 NURSING	64,800	S.I.R. MANAGEMENT, INC.	100.00%	19,493	(45,307)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,940	2,940
19	V	19 PROFESSIONAL FEES	194,400	S.I.R. MANAGEMENT, INC.	100.00%	3,262	(191,138)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	379	379
21	V	21 CLERICAL & GENERAL	64,800	S.I.R. MANAGEMENT, INC.	100.00%	44,659	(20,141)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	512	512
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	12,294	12,294
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,454	1,454
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,718	5,718
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(32,413)	(32,413)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	12,153	12,153
28	V						
29	V	17 ADMINISTRATIVE	929,451	S.I.R. MANAGEMENT, INC.	100.00%	33,462	(895,989)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,075	1,075
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	135,904	135,904
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	26,059	26,059
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,285,851			\$ 283,141	\$ * (1,002,710)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY SALARIES	\$ 32,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 8,428	\$ (23,972)
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,302	1,302
17	V	10 NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	9,654	9,654
18	V	15 EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,467	1,467
19	V	17 ADMIN./LEGAL SALARIES	16,200	S.I.R. MANAGEMENT, INC.	100.00%	125,744	109,544
20	V	19 FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	19,469	19,469
21	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	22,510	22,510
22	V						
23	V						
24	V	10A DIRECTOR OF SPECIAL REHAB	32,400	S.I.R. MANAGEMENT, INC.	100.00%	8,214	(24,186)
25	V	15 EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,288	1,288
26	V						
27	V	6 MAINTENANCE SALARIES	24,794	S.I.R. MANAGEMENT, INC.	100.00%	17,086	(7,708)
28	V	7 EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,113	3,113
29	V						
30	V	5 UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	3,037	3,037
31	V	6 REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	869	869
32	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	74	74
33	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	88	88
34	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	180	180
35	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	14,547	14,547
36	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	9,513	9,513
37	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	9,102	9,102
38	V						
39	Total		\$ 105,794			\$ 255,685	\$ * 149,891

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	23,072	Xcel Supply, LLC	100.00%	20,953	(2,119)	16
17	V	4 Laundry	4,582	Xcel Supply, LLC	100.00%	4,161	(421)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	171,436	Xcel Supply, LLC	100.00%	155,693	(15,743)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 199,090			\$ 180,807	\$ * (18,283)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 546,996	\$ 546,996
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	546,996	CCS Employee Benefits Group	100.00%		(546,996)
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 546,996			\$ 546,996	\$ *

\* 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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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: 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		
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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Regency Rehabilitation Center # 0049841 Report Period Beginning: 01/01/09 Ending: 12/31/09

## 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	Bryan Barrish	Administrative	Owner	12.15%	See Attached	3.27	8.18%	Alloc. Salary	\$ 21,229	17-7	1
2	Mike Giannini	Administrative	Owner	10.42%	See Attached	3.81	9.53%	Alloc. Salary	18,174	17-7	2
3	Eric Rothner	Administrative	Relative	0.00%	See Attached	0.76	1.63%	Alloc. Salary	10,887	17-7	3
4	Nenita Guzman	Dietary	Relative	0.00%	See Attached	5.44	10.88%	Alloc. Salary	8,428	1-7	4
5	Lori Barrish	Administrative	Relative	1.56%	none	41.54	100.00%	Salary	112,523	17-1	5
6	Sarah Barrish	Administrative	Relative	0.00%	See Attached	4.35	10.88%	Alloc. Salary	11,101	17-7	6
7	Burton Behr	Administrative	Relative	3.13%	See Attached	4.35	10.88%	Alloc. Salary	3,304	17-7	7
8	Kristen Barrish	Clerical	Relative	0.00%	See Attached	1.85	10.88%	Alloc. Salary	1,471	21-7	8
9	Tom Winter	Administrative	Owner	1.56%	See Attached	6.26	10.43%	Alloc. Salary	20,334	17-7	9
10											10
11											11
12											12
13								TOTAL	\$ 207,451		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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	87,766	\$ 14,986	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		87,766	1,204	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	87,766	19,493	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		87,766	2,940	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	87,766	3,262	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		87,766	379	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	87,766	44,659	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		87,766	512	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		87,766	12,294	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		87,766	1,454	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		87,766	5,718	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		87,766	(32,413)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		87,766	12,153	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	87,766	33,462	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		87,766	1,075	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	87,766	135,904	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		87,766	26,059	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 283,141	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	806,183	12	\$ 77,418	\$ 77,418	87,766	\$ 8,428	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		87,766	1,302	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	87,766	9,654	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		87,766	1,467	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	87,766	125,744	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		87,766	19,469	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		87,766	22,510	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	32,400	8,214	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		32,400	1,288	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	24,794	17,086	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		24,794	3,113	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		1,384	3,037	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		1,384	869	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		1,384	74	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		1,384	88	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		1,384	180	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		1,384	14,547	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		1,384	9,513	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		1,384	9,102	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 255,685	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 CCS Employee Benefits Group, Inc.  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					20,953	2
3	4	Laundry	Direct Allocation					4,161	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					155,693	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$ 180,807	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Lake Forest Bank		X	Line of Credit			\$	\$ 705,000		\$ 80,434	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule							19,550,000			5								
<b>Working Capital</b>																			
6	Alloc. - SIR Management	X								(22,900)	6								
7	Regency Bldng Company									(814)	7								
8	See Supplemental Schedule							1,150,000			8								
9	<b>TOTAL Facility Related</b>						\$	\$ 21,405,000		\$ 56,720	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(43,736)	10								
11			X								11								
12											12								
13	See Supplemental Schedule										13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (43,736)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 21,405,000		\$ 12,983	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Mortgage Payable		X				\$	\$ 19,550,000			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term							19,550,000				7						
	<b>Working Capital</b>																	
8							\$	\$			\$	8						
9	Member Loan	X						1,150,000				9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital							1,150,000				14						
	<b>B. Non-Facility Related*</b>																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related											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.)

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 (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>611,764</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>613,781</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,017</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>615,500</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>		\$	<b>11,763</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>629,280</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	_____	8	
	2005	_____	9	
	2006	_____	10	
	2007	<b>552,631</b>	11	
	2008	<b>604,679</b>	12	
<b>Beginning Accrual Adjusted</b>				13
<b>Allocation From SIR Management= \$9,102</b>				14
<b>Allocation From 6625 Milwaukee: \$20,500</b>				15
				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.**

SEE ACCOUNTANTS' COMPILATION REPORT





Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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 Rehabilitation Center, LLC- Rehabilitation Company- Separate Building  
Regency Senior Day Care- Home Health and Adult Day Care Agency- Separate Building  
Health Trends, LTC- Home Health Agency- Separate Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	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

\*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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	Related Building Company (Pages 12F & 12G)	12,900,000	16,585		330,769	314,184	16,585	67
68	Related Party Allocations (Pages 12H & 12I)	157,945	7,071		5,559	(1,512)	56,592	68
69	Financial Statement Depreciation		38,154			(38,154)		69
70	TOTAL (lines 4 thru 69)	\$ 13,057,945	\$ 61,810		\$ 336,328	\$ 274,518	\$ 73,177	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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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>		\$ 13,057,945	\$ 61,810		\$ 336,328	\$ 274,518	\$ 73,177	1
2	Hvac Work	2008	31,540		20	1,577	1,577	3,023	2
3	Hvac Work	2008	6,893		20	345	345	661	3
4	Flooring	2008	20,700		20	2,957	2,957	5,421	4
5	Hvac Work	2008	11,262		20	563	563	1,032	5
6	Hvac Work	2008	6,535		20	327	327	599	6
7	Hvac Work	2008	13,495		20	675	675	1,237	7
8	Hvac Work	2008	3,900		20	195	195	358	8
9	Hvac Work	2008	11,798		20	590	590	1,032	9
10	Hvac Work	2008	8,425		20	421	421	737	10
11	Hvac Work	2008	5,479		20	274	274	457	11
12	Wallpaper Dining	2008	9,983		20	499	499	790	12
13	Flooring	2008	7,214		20	361	361	571	13
14	Boiler	2008	17,261		20	863	863	1,367	14
15	Compressor	2008	2,106		20	421	421	667	15
16	Parking Lot Work	2008	14,140		20	943	943	1,335	16
17	Cooling Coil	2008	18,430		20	922	922	1,152	17
18	Mixing Valve	2008	6,492		20	325	325	406	18
19	Dampers	2008	4,379		20	219	219	274	19
20	Hvac Work	2008	6,333		20	317	317	369	20
21	Hvac Work	2008	25,218		20	1,261	1,261	1,471	21
22	A/C Units	2008	7,452		20	373	373	559	22
23	Receptacles	2008	3,818		20	191	191	255	23
24	Window Shades	2008	7,365		20	368	368	614	24
25	Drapes	2008	2,601		20	130	130	206	25
26	Generator Supplies & Maintenance	2008	2,733		20	137	137	194	26
27	Cooling Tower Bearing & Belt Repair	2008	2,616		20	131	131	174	27
28	Electrical Elevator Repairs	2008	2,599		20	130	130	162	28
29	Replace Tower Fan Motor	2008	5,604		20	280	280	350	29
30	Keys & Locks For Med Rooms	2008	6,198		20	310	310	387	30
31	Xmmt Freight Error Repair	2008	4,022		20	201	201	285	31
32	Smoke Detectors	2008	2,881		20	144	144	252	32
33	Shower Faucets	2009	12,940		20	647	647	647	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,350,357	\$ 61,810		\$ 353,425	\$ 291,615	\$ 100,221	34

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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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>		\$ 13,350,357	\$ 61,810		\$ 353,425	\$ 291,615	\$ 100,221	1
2	Ejector Pump	2009	6,242		20	208	208	208	2
3	Fire Dampers	2009	5,986		20	200	200	200	3
4	Fire Dampers	2009	3,246		20	108	108	108	4
5	Security System	2009	2,825		20	141	141	141	5
6	Door Alarms	2009	5,697		20	285	285	285	6
7	Ductwork	2009	13,130		20	219	219	219	7
8	Plumbing Work	2009	3,450		20	43	43	43	8
9	Roof	2009	100,900		20	1,261	1,261	1,261	9
10	Window Treatments	2009	3,458		20	173	173	173	10
11	Hot Water Work	2009	3,077		20	141	141	141	11
12	Condenser	2009	11,395		20	475	475	475	12
13	Rooftop Hvac Fans	2009	20,668		20	861	861	861	13
14	Dryer Vent/Exhaust	2009	14,755		20	492	492	492	14
15	Storm Drain Pipe Repair	2009	5,800		20	290	290	290	15
16	Exhaust Fan And Dampers	2009	9,809		20	490	490	490	16
17	Stats And Pneumatic Tubing	2009	4,276		20	214	214	214	17
18	Hvac Controller	2009	5,720		20	286	286	286	18
19	Extending Ductwork	2009	3,593		20	180	180	180	19
20	Boiler Report	2009	5,323		20	266	266	266	20
21	Chiller Pm Work	2009	4,526		20	226	226	226	21
22	Sprinkler Heads	2009	6,000		20	300	300	300	22
23	Fire Alarm Repair	2009	2,994		20	150	150	150	23
24	Replace Smoke Damper	2009	2,887		20	144	144	144	24
25	Sprinkler System Repair	2009	3,433		20	172	172	172	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>		\$ 13,599,547	\$ 61,810		\$ 360,750	\$ 298,940	\$ 107,546	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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	
1		\$ 13,599,547	\$ 61,810		\$ 360,750	\$ 298,940	\$ 107,546	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 13,599,547	\$ 61,810		\$ 360,750	\$ 298,940	\$ 107,546	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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	
1		\$ 13,599,547	\$ 61,810		\$ 360,750	\$ 298,940	\$ 107,546	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 13,599,547	\$ 61,810		\$ 360,750	\$ 298,940	\$ 107,546	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>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	6631 Milwaukee, LLC	1976	12,900,000	16,585	39	330,769	314,184	16,585	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 12,900,000	\$ 16,585		\$ 330,769	\$ 314,184	\$ 16,585

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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>SIR- SIR</b>	1993	48,644	1,544	35	1,390	(154)	22,932	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>S.I.R. Properties- SIR Management- Allocation</b>	2009	2,921	1,669	20	117	(1,552)	117	9
10	<b>S.I.R. Properties- SIR Management- Allocation</b>	2007	852	123	20	43	(80)	128	10
11	<b>S.I.R. Properties- SIR Management- Allocation</b>	2002	193		20	10	10	73	11
12	<b>S.I.R. Properties- SIR Management- Allocation</b>	1999	6,164	308	20	308		3,236	12
13	<b>S.I.R. Properties- SIR Management- Allocation</b>	1998	2,946		20	147	147	1,694	13
14	<b>S.I.R. Properties- SIR Management- Allocation</b>	1997	183		20	9	9	124	14
15	<b>S.I.R. Properties- SIR Management- Allocation</b>	1994	463	12	20	23	11	359	15
16	<b>S.I.R. Properties- SIR Management- Allocation</b>	1993	789	4	20	39	35	651	16
17									17
18	<b>SIR Management- Allocation</b>	1993	12,333	343	20	611	268	10,394	18
19	<b>SIR Management- Allocation</b>	1994	38		20			38	19
20	<b>SIR Management- Allocation</b>	1995	282		20	14	14	203	20
21	<b>SIR Management- Allocation</b>	1997	18,950	424	20	947	523	12,137	21
22	<b>SIR Management- Allocation</b>	1999	1,490		20	75	75	763	22
23	<b>SIR Management- Allocation</b>	2000	1,759		20	88	88	839	23
24	<b>SIR Management- Allocation</b>	2007	5,652	1,008	20	283	(725)	620	24
25	<b>SIR Management- Allocation</b>	2008	15,578	1,558	20	982	(576)	1,811	25
26	<b>SIR Management- Allocation</b>	2009	38,708	78	20	473	395	473	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 157,945	\$ 7,071		\$ 5,559	\$ (1,512)	\$ 56,592	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 Rehabilitation Center

# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 140,036	\$ 7,246	\$ 20,121	\$ 12,875	10	\$ 33,923	71
72	Current Year Purchases	69,337	228	2,954	2,726	10	2,954	72
73	Fully Depreciated Assets	40,716		387	387	10	40,716	73
74								74
75	TOTALS	\$ 250,089	\$ 7,474	\$ 23,462	\$ 15,988		\$ 77,593	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)	\$ 13,849,636	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,284	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,212	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 314,928	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 185,139	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	Office Building - 2009	\$ 500,000	\$ 534	\$ 534	86
87	Land- Vacant Parcel - 2009	400,000			87
88	Land- Office Building - 2009	150,000			88
89					89
90					90
91	TOTALS	\$ 1,050,000	\$ 534	\$ 534	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: FRN Healthcare, LLC - Unrelated

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	<u>Building Company</u>				<u>1,496,310</u>			5
6								6
7	TOTAL				\$ <u>1,496,310</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: Purchase Option Available \*

**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: \$ 18,508 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	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

**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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	462,785	\$		\$	462,785	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				85,190				85,190	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				570,777				570,777	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					412,816			412,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <b>See Supplemental</b>							231,105			231,105	13
14	<b>TOTAL</b>			\$		\$	1,118,752	\$	643,921	\$	1,762,673	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 Rehabilitation Center# 0049841Report Period Beginning: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 14,393	\$ 34,327	1
2	Cash-Patient Deposits	107,506	107,506	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,053,304	3,092,241	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,219	24,219	6
7	Other Prepaid Expenses	5,104	5,104	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		5,714	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,204,526	\$ 3,269,111	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,500,000	13
14	Buildings, at Historical Cost		13,900,000	14
15	Leasehold Improvements, at Historical Cost	396,279	507,125	15
16	Equipment, at Historical Cost	210,944	562,873	16
17	Accumulated Depreciation (book methods)	(55,492)	(72,611)	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>	1,401,319	7,542,328	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,953,050	\$ 23,939,715	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,157,576	\$ 27,208,826	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,417,525	\$ 2,319,809	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	117,633	117,633	28
29	Short-Term Notes Payable	705,000	1,855,000	29
30	Accrued Salaries Payable	404,282	404,282	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,303	27,303	31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,000	615,500	32
33	Accrued Interest Payable		127,084	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	20,000	65,537	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,787,743	\$ 5,532,148	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,550,000	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 (sum of lines 39 thru 44)</b>	\$	\$ 19,550,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,787,743	\$ 25,082,148	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,369,833	\$ 2,126,678	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,157,576	\$ 27,208,826	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,000,014</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,000,014</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,245,819	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,245,819</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Members Capital</b>	124,000	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>124,000</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,369,833</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center# 0049841Report Period Beginning: 01/01/09Ending: 12/31/09

**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	\$ 17,217,477	1
2	Discounts and Allowances for all Levels	(4,023,526)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 13,193,951</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,792,932	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,792,932</b>	<b>8</b>
<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	1,500	13
14	Non-Patient Meals	933	14
15	Telephone, Television and Radio	13,090	15
16	Rental of Facility Space		16
17	Sale of Drugs	389,334	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,794	19
20	Radiology and X-Ray	14,700	20
21	Other Medical Services	78,337	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 537,688</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	43,736	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 43,736</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	400,458	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 400,458</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 16,968,765</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,378,563	31
32	Health Care	5,084,847	32
33	General Administration	3,902,585	33
<b>B. Capital Expense</b>			
34	Ownership	2,248,943	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,943,758	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>	<b>\$ 15,722,946</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,245,819</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,245,819</b>	<b>43</b>

\* 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 Rehabilitation Center**

# **0049841**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	2,394	2,817	\$ 135,031	\$ 47.93	1
2	Assistant Director of Nursing	1,678	1,881	67,706	35.99	2
3	Registered Nurses	52,920	55,613	1,438,608	25.87	3
4	Licensed Practical Nurses	25,297	26,712	579,949	21.71	4
5	CNAs & Orderlies	153,936	164,229	1,707,381	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,931	9,911	126,725	12.79	8
9	Activity Director	3,103	3,253	51,681	15.89	9
10	Activity Assistants	17,635	18,847	196,504	10.43	10
11	Social Service Workers	12,209	13,713	220,384	16.07	11
12	Dietician	1,954	2,098	63,368	30.20	12
13	Food Service Supervisor	1,943	2,215	42,849	19.34	13
14	Head Cook	5,036	5,725	75,933	13.26	14
15	Cook Helpers/Assistants	30,092	32,826	285,338	8.69	15
16	Dishwashers					16
17	Maintenance Workers	5,243	5,544	100,567	18.14	17
18	Housekeepers	30,871	33,476	297,629	8.89	18
19	Laundry	16,503	18,226	149,249	8.19	19
20	Administrator	1,861	2,086	112,523	53.94	20
21	Assistant Administrator	1,950	2,086	77,615	37.21	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,195	9,485	141,647	14.93	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>	10,965	11,787	266,262	22.59	33
34	TOTAL (lines 1 - 33)	393,716	422,530	\$ 6,136,949 *	\$ 14.52	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	491	\$ 22,531	01-03	35
36	Medical Director	Monthly	52,800	09-03	36
37	Medical Records Consultant	Monthly	4,344	10-03	37
38	Nurse Consultant	Monthly	64,800	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	Monthly	443	10a-03	43
44	Activity Consultant	171	8,572	11-03	44
45	Social Service Consultant	Monthly	2,103	12-03	45
46	Other(specify) <u>Dir of Food Srvc</u>	Monthly	32,400	01-03	46
47	<u>Dir of Specialized Services</u>	Monthly	32,400	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	662	\$ 222,453		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	364	11,916	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	364	\$ 11,916		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lori Barrish	Administrator	1.56%	\$ 112,523	Workers' Compensation Insurance	\$ 142,659	IDPH License Fee	\$ 994	
Jacqueline Gully	Assit Admin	0	77,615	Unemployment Compensation Insurance	54,277	Advertising: Employee Recruitment	34,500	
				FICA Taxes	453,698	Health Care Worker Background Check		
				Employee Health Insurance	481,513	(Indicate # of checks performed <u>704</u> )	7,040	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	3,584	
				Employee Benefits- Other	15,828	Dues and Subscriptions	16,393	
				401K Contributions	6,454	Advertising	53,925	
						Yellow Page Advertising	200	
						See Supplemental Schedule	379	
						Less: Public Relations Expense (		
						Non-allowable advertising	(53,925)	
						Yellow page advertising	(200)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 190,138					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,154,429	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 62,890	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SIR Management- Management Fees			\$ 744,051				Out-of-State Travel	\$
SIR Management- Dir of Admin Services			64,800					
SIR Management- Dir of Ancillary Charges			66,600					
See Supplemental Schedule			70,200				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 945,651					
							Seminar Expense	3,285
							Alloc.- SIR Management	512
							Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 3,797

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center# 0049841

Report Period Beginning:

01/01/09

Ending:

12/31/09**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 \$12595
- (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? N/A
- (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? N/A
- (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. \$ 34,455 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 933
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.