

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	63,994	6,700	15,064	85,758	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,994	6,700	15,064	85,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.32%

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 10,501

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	520,647	83,286	61,360	665,293		665,293	(26,464)	638,829		1
2	Food Purchase		573,854		573,854	(34,164)	539,690	(446)	539,244		2
3	Housekeeping	346,320	88,300		434,620		434,620		434,620		3
4	Laundry	163,306	59,974		223,280		223,280		223,280		4
5	Heat and Other Utilities			281,828	281,828		281,828	(5,002)	276,826		5
6	Maintenance	150,726	60,453	305,246	516,425		516,425	(27,081)	489,344		6
7	Other (specify):*							8,144	8,144		7
8	TOTAL General Services	1,180,999	865,867	648,434	2,695,300	(34,164)	2,661,136	(50,849)	2,610,287		8
	B. Health Care and Programs										
9	Medical Director			44,400	44,400		44,400		44,400		9
10	Nursing and Medical Records	4,228,090	264,997	137,234	4,630,321		4,630,321	(69,400)	4,560,921		10
10a	Therapy	170,245		2,007	172,252		172,252	(12,551)	159,701		10a
11	Activities	266,517	13,530	3,795	283,842		283,842		283,842		11
12	Social Services	146,066		11,775	157,841		157,841		157,841		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,128	5,128		15
16	TOTAL Health Care and Programs	4,810,918	278,527	199,211	5,288,656		5,288,656	(76,823)	5,211,833		16
	C. General Administration										
17	Administrative	202,769		970,068	1,172,837		1,172,837	(823,143)	349,694		17
18	Directors Fees										18
19	Professional Services			354,383	354,383	(28,219)	326,164	(198,697)	127,467		19
20	Dues, Fees, Subscriptions & Promotions			97,176	97,176		97,176	(50,493)	46,683		20
21	Clerical & General Office Expenses	208,166	39,634	562,931	810,731		810,731	(321,693)	489,038		21
22	Employee Benefits & Payroll Taxes			1,300,568	1,300,568	34,164	1,334,732		1,334,732		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,227	11,227		11,227	1,229	12,456		24
25	Other Admin. Staff Transportation			6,805	6,805		6,805	12,473	19,278		25
26	Insurance-Prop.Liab.Malpractice			203,330	203,330		203,330	824	204,154		26
27	Other (specify):*							52,563	52,563		27
28	TOTAL General Administration	410,935	39,634	3,506,488	3,957,057	5,945	3,963,002	(1,326,937)	2,636,065		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,402,852	1,184,028	4,354,133	11,941,013	(28,219)	11,912,794	(1,454,609)	10,458,185		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Regency Rehabilitation Ctr

#0049841

Report Period Beginning:

01/01/13

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			94,891	94,891		94,891	916,648	1,011,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,126	70,126		70,126	1,476,464	1,546,590			32
33	Real Estate Taxes					28,219	28,219	827,028	855,247			33
34	Rent-Facility & Grounds			3,060,000	3,060,000		3,060,000	(3,060,000)				34
35	Rent-Equipment & Vehicles			5,622	5,622		5,622	7,846	13,468			35
36	Other (specify):*											36
37	TOTAL Ownership			3,230,639	3,230,639	28,219	3,258,858	167,986	3,426,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		578,589	1,017,645	1,596,234		1,596,234		1,596,234			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			632,305	632,305		632,305		632,305			42
43	Other (specify):*	163,068			163,068		163,068	(163,068)				43
44	TOTAL Special Cost Centers	163,068	578,589	1,649,950	2,391,607		2,391,607	(163,068)	2,228,539			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,565,920	1,762,617	9,234,722	17,563,259		17,563,259	(1,449,690)	16,113,569			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,731)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	199,483	30		9
10	Interest and Other Investment Income	(4,382)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(446)	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	(11,650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(429,948)	21		24
25	Fund Raising, Advertising and Promotional	(31,364)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(250,710)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (541,747)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(907,943)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (907,943)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,449,690)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Regency Rehabilitation Ctr

ID# 0049841

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non Allowable Legal	\$ (17,463)	19	1
2	Marketing Salary	(163,068)	43	2
3	Misc. Income	(325)	21	3
4	Bank Fees	(6,130)	21	4
5	Theft & Damage	(498)	21	5
6	State Replacement Tax	(5,500)	21	6
7	Additional R&M	3,931	06	7
8	Building Co. - Fees	(305)	21	8
9	Building Co. - Amortization	(24,761)	31	9
10	Building Co. - Office	(10)	21	10
11	Building Co. - Professional	(3,528)	19	11
12	Cope Dues	(8,069)	20	12
13	Capitalized R&M	(17,573)	06	13
14	PPA - Liability Settlement	(1,700)	26	14
15	PPA - Nursing Supplies	(5,711)	10	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
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(250,710)	49

Regency Rehabilitation Ctr

ID# 0049841

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Rehabilitation Ctr# 0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(26,464)								(26,464)	1
2	Food Purchase	(446)											(446)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,731)	4,984		2,745								(5,002)	5
6	Maintenance	(13,642)	2,663	(23,276)	7,174								(27,081)	6
7	Other (specify):*			789	7,355								8,144	7
8	TOTAL General Services	(26,819)	7,647	(22,487)	(9,190)								(50,849)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,711)		(74,117)	10,428								(69,400)	10
10a	Therapy				(12,551)								(12,551)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,607	3,521								5,128	15
16	TOTAL Health Care and Programs	(5,711)		(72,510)	1,398								(76,823)	16
	C. General Administration													
17	Administrative			(934,761)	111,618								(823,143)	17
18	Directors Fees													18
19	Professional Services	(20,991)	3,528	(201,427)	20,193								(198,697)	19
20	Fees, Subscriptions & Promotions	(51,083)		590									(50,493)	20
21	Clerical & General Office Expenses	(442,716)	315	120,615	93								(321,693)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,229									1,229	24
25	Other Admin. Staff Transportation			12,473									12,473	25
26	Insurance-Prop.Liab.Malpractice	(1,700)		2,329	195								824	26
27	Other (specify):*			30,382	22,181								52,563	27
28	TOTAL General Administration	(516,490)	3,843	(968,570)	154,280								(1,326,937)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(549,020)	11,490	(1,063,567)	146,488								(1,454,609)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13 Ending:

12/31/13

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	199,483	708,883		8,282								916,648	30
31	Amortization of Pre-Op. & Org.	(24,761)	24,761											31
32	Interest	(4,382)	1,493,521	(21,296)	8,621								1,476,464	32
33	Real Estate Taxes		819,081		7,947								827,028	33
34	Rent-Facility & Grounds		(3,060,000)										(3,060,000)	34
35	Rent-Equipment & Vehicles			7,846									7,846	35
36	Other (specify):*													36
37	TOTAL Ownership	170,340	(13,754)	(13,450)	24,850								167,986	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(163,068)											(163,068)	43
44	TOTAL Special Cost Centers	(163,068)											(163,068)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(541,747)	(2,264)	(1,077,017)	171,338								(1,449,690)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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 Rental Income	\$ 2,340,000	6631 Milwaukee, LLC	100.00%	\$	\$ (2,340,000)	1
2	V	34 Rental Income Taxes	720,000	6631 Milwaukee, LLC	100.00%		(720,000)	2
3	V	21 Fees		6631 Milwaukee, LLC	100.00%	305	305	3
4	V	30 Depreciation - SNF		6631 Milwaukee, LLC	100.00%	708,883	708,883	4
5	V	31 Amortization		6631 Milwaukee, LLC	100.00%	24,761	24,761	5
6	V	32 Interest-LFB Loans		6631 Milwaukee, LLC	100.00%	251,117	251,117	6
7	V	32 Interest		6631 Milwaukee, LLC	100.00%	1,242,404	1,242,404	7
8	V	21 Office		6631 Milwaukee, LLC	100.00%	10	10	8
9	V	19 Professional Fees		6631 Milwaukee, LLC	100.00%	3,528	3,528	9
10	V	33 Real Estate Taxes		6631 Milwaukee, LLC	100.00%	819,081	819,081	10
11	V	06 Repairs		6631 Milwaukee, LLC	100.00%	2,663	2,663	11
12	V	05 Utilities		6631 Milwaukee, LLC	100.00%	4,984	4,984	12
13	V							13
14	Total		\$ 3,060,000			\$ 3,057,736	\$ * (2,264)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 36,000	S.I.R. MANAGEMENT, INC.	100.00%	\$ 12,724	\$ (23,276)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	789	789
17	V	10 NURSING	86,400	S.I.R. MANAGEMENT, INC.	100.00%	12,283	(74,117)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,607	1,607
19	V	19 PROFESSIONAL FEES	226,800	S.I.R. MANAGEMENT, INC.	100.00%	20,063	(206,737)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	590	590
21	V	21 CLERICAL & GENERAL	86,400	S.I.R. MANAGEMENT, INC.	100.00%	70,211	(16,189)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,229	1,229
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	12,473	12,473
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,329	2,329
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,869	9,869
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(21,296)	(21,296)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,846	7,846
28	V						
29	V	17 ADMINISTRATIVE	970,068	S.I.R. MANAGEMENT, INC.	100.00%	35,307	(934,761)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	5,310	5,310
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	136,804	136,804
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,513	20,513
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,405,668			\$ 328,651	\$ * (1,077,017)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	\$ 36,000	S.I.R. MANAGEMENT, INC.	100.00%	\$ 9,536	\$ (26,464)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,254	1,254	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	10,428	10,428	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,358	1,358	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	111,618	111,618	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	20,113	20,113	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	22,181	22,181	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,800	S.I.R. MANAGEMENT, INC.	100.00%	16,249	(12,551)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,163	2,163	25
26	V								26
27	V	6	MAINTENANCE SALARIES	34,822	S.I.R. MANAGEMENT, INC.	100.00%	40,971	6,149	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	6,101	6,101	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,745	2,745	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,025	1,025	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	80	80	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	93	93	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	195	195	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,282	8,282	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	8,621	8,621	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,947	7,947	37
38	V								38
39	Total		\$ 99,622				\$ 270,960	\$ * 171,338	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$ 40,532	Long Term Care Laboratory, LLC	100.00%	\$ 40,532	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 40,532			\$ 40,532	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES	34.722%	ALBANY CARE INC	EVANSTON	6631 MILWAUKEE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LTD PARTNERSHIP	12.153%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	12.153%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	JOSHUA DAVID BEHR	1.563%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	LINDSEY ERIN BEHR	1.563%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	LORI BARRISH	1.563%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	MICHAEL GIANNINI TRUST	10.417%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				7
8	RALPH GESULADO	12.153%	GREENWOOD CARE, INC.	EVANSTON				8
9	RALPH GESULADO CHILDREN'S TRUST	12.153%	MAPLEWOOD CARE, INC.	ELGIN				9
10	THOMAS WINTER	1.563%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				10
11			ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12			WILSON CARE, INC.	CHICAGO				12
13			WESLEY REHABILITATION CENTER	AUBURN, IN				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Michael Giannini	Relative	Administrative	0%	See Attached	3.64	9.10%	Alloc. Salary	\$ 17,421	17-07	1
2	Tom Winter	Owner	Administrative	1.56%	See Attached	6.25	10.42%	Alloc. Salary	20,821	17-07	2
3	Lori Barrish	Owner	Administrator	1.56%	See Attached	55	100.00%	Salary	111,767	17-01	3
4	Bryan Barrish	Relative	Administrative	0%	See Attached	4.16	9.24%	Alloc. Salary	20,821	17-07	4
5	Sarah Barrish	Relative	Administrative	0%	See Attached	4.68	10.40%	Alloc. Salary	9,908	17-07	5
6	Bart Barrish	Relative	Administrative	0%	See Attached	40	100.00%	Salary	70,000	17-01	6
7	Kirsten Barrish	Relative	Clerical	0%	See Attached	5.21	10.42%	Alloc. Salary	5,246	21-07	7
8	Matthew Winter	Relative	Clerical	0%	See Attached	0.64	10.49%	Alloc. Salary	329	21-07	8
9	Nenita Guzman	Relative	Dietary	0%	See Attached	5.21	10.42%	Alloc. Salary	9,536	01-07	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 265,849		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 Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	6	REPAIRS AND MAINT.	PATIENT DAYS	823,778	14	\$ 122,226	\$ 54,106	85,758	\$ 12,724	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581	85,758	85,758	789	2
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	85,758	12,283	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435	85,758	85,758	1,607	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	85,758	20,063	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665	85,758	85,758	590	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	85,758	70,211	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805	85,758	85,758	1,229	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815	85,758	85,758	12,473	9
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368	85,758	85,758	2,329	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799	85,758	85,758	9,869	11
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)	85,758	85,758	(21,296)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364	85,758	85,758	7,846	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	85,758	35,307	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011	85,758	85,758	5,310	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	85,758	136,804	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046	85,758	85,758	20,513	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,156,964	\$ 2,409,562		\$ 328,651	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	DIETARY SALARIES	PATIENT DAYS	823,778	14	\$ 91,605	\$ 91,605	85,758	\$ 9,536	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049		85,758	1,254	2
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	85,758	10,428	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047		85,758	1,358	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	85,758	111,618	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200		85,758	20,113	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069		85,758	22,181	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	28,800	16,249	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	293,544	14	22,047		28,800	2,163	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	34,822	40,971	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242		34,822	6,101	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365		1,341	2,745	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845		1,341	1,025	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768		1,341	80	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896		1,341	93	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870		1,341	195	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536		1,341	8,282	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793		1,341	8,621	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319		1,341	7,947	23
24										24
25	TOTALS					\$ 2,672,494	\$ 1,874,448		\$ 270,960	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Long Term Care Laboratory, LLC
 Street Address 2458 Elmhurst Road
 City / State / Zip Code Elk Grove Village, IL 60007
 Phone Number (630)422-7800
 Fax Number (847)422-1360

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	39	Ancillary	Direct Allocation		\$	\$		\$ 40,532	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				\$	\$		\$ 40,532	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Mortgage Payable		X				\$	\$ 19,633,408			\$ 1,242,404	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Lake Forest Bank		X	Line of Credit				2,150,000			70,126	6					
7	Lake Forest Bank		X	Member Loan				4,998,000			251,117	7					
8	See Supplemental Schedule							4,000,000			8,621	8					
9	TOTAL Facility Related						\$	\$ 30,781,408			\$ 1,572,268	9					
B. Non-Facility Related*																	
10	Interest Income		X								(4,382)	10					
11	Alloc from S.I.R. Mnmgt	X									(21,296)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (25,678)	14					
15	TOTALS (line 9+line14)						\$	\$ 30,781,408			\$ 1,546,590	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 Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Member Loan		X				\$	\$ 4,000,000			\$					
9	Allocated from S.I.R. Managem	X									8,621					
10																
11																
12																
13																
14	TOTAL Working Capital							4,000,000			8,621					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* 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.)

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Rehabilitation Ctr COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049841
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-31-401-046-0000</u>	<u>Long Term Care Property</u>	\$ <u>783,780.79</u>	\$ <u>783,780.79</u>
2. <u>See Attached</u>	<u>Home Office</u>	\$ <u>106,516.99</u>	\$ <u>8,685.88</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>890,297.78</u></u>	\$ <u><u>792,466.67</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Regency Rehabilitation Ctr

0049841 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,951 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 Care 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2009</u>	<u>\$ 875,000</u>	1
2					2
3	TOTALS			\$ 875,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	300			1976	\$ 12,900,000	\$ 547,487	39	\$ 330,769	\$ (216,718)	\$ 1,274,724	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2008		252,676		20	14,792	14,792	82,604	9
10	Various		2009		248,314		20	12,842	12,842	57,940	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		9,235,970			462,975	462,975	1,490,303	67
68		188,699		5,245	7,369	2,124	85,212	68
69				94,891		(94,891)		69
70		\$ 22,825,659	\$ 647,623		\$ 828,746	\$ 181,123	\$ 2,990,783	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 22,825,659	\$ 647,623		\$ 828,746	\$ 181,123	\$ 2,990,783	1
2	Dryer Exhaust	2010	29,940		20	1,497	1,497	5,614	2
3	Hvac Work	2010	2,985		20	299	299	945	3
4	Nurse Call System	2010	3,078		20	308	308	975	4
5	Exit Doors	2010	4,780		20	239	239	797	5
6	Elevator Work	2010	3,126		20	156	156	599	6
7	Carpet Installation	2010	3,981		20	199	199	730	7
8	Sprinkler Work	2010	3,965		20	198	198	776	8
9	Elevator Renovations	2010	4,689		20	234	234	723	9
10	Laminate Panels, Hand Rails, Coffe Ceilings	2010	9,000		20	450	450	1,388	10
11	Flooring	2010	5,634		20	282	282	869	11
12	Fire System Tank	2011	2,985		20	149	149	448	12
13	Security Camera System	2011	7,967		20	1,593	1,593	4,515	13
14	Hvac- Coil Replacement	2011	12,168		20	608	608	1,622	14
15	Fire System- Sensor Modules	2011	3,064		20	153	153	409	15
16	Security Camera System	2011	8,612		20	1,722	1,722	4,737	16
17	Elevator Motor Work	2011	9,175		20	459	459	1,185	17
18	Elevator Door Operator	2011	8,547		20	427	427	1,068	18
19	Overbed Lights (24)	2011	2,330		20	233	233	563	19
20	Magnetic Door Closers	2011	7,474		20	374	374	872	20
21	Fire Pump Work	2011	3,225		20	161	161	376	21
22	Fire Alarm System Work	2011	4,641		20	232	232	522	22
23	Fire Doors	2011	3,300		20	165	165	358	23
24	Closet Soffit	2011	6,497		20	325	325	893	24
25	Prep/Paint 16 Rooms	2011	6,784		20	339	339	1,046	25
26	Water Purification System	2011	3,831		20	192	192	591	26
27	Repair Air Handler	2011	3,941		20	197	197	558	27
28	Replace Belts & Exhaust Fans	2011	15,623		20	781	781	2,148	28
29	Elevator Work	2011	3,778		20	189	189	535	29
30	Replace Valves	2011	3,190		20	160	160	439	30
31	Repair Coel	2011	2,795		20	140	140	419	31
32	Replace Control & Valve	2011	8,491		20	425	425	1,274	32
33	Protective Bumpers	2012	4,200		20	420	420	840	33
34	TOTAL (lines 1 thru 33)		\$ 23,029,454	\$ 647,623		\$ 842,053	\$ 194,430	\$ 3,029,615	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 23,029,454	\$ 647,623		\$ 842,053	\$ 194,430	\$ 3,029,615	1
2	Boiler Work	2012	10,499		20	525	525	1,050	2
3	Boiler Work	2012	9,418		20	471	471	863	3
4	Boiler Work	2012	4,109		20	205	205	342	4
5	Fire Panel Work	2012	3,982		20	199	199	315	5
6	Ceiling Fan Insulation	2012	11,185		20	559	559	839	6
7	Privacy Curtains	2012	3,034		20	152	152	177	7
8	Tuckpointing	2012	12,000		20	600	600	700	8
9	Compressor	2012	5,348		20	267	267	290	9
10	Tuckpointing & Caulking	2012	49,045		20	2,452	2,452	2,657	10
11	Handrails	2012	5,325		20	266	266	444	11
12	Installed Piping In 2 Showers	2012	3,981		20	199	199	332	12
13	Monitor Modules Floors 1, 2, 3, 4	2012	2,818		20	141	141	235	13
14	Install Crash Rail - 3Rd And 4Th Floor Dining Rooms	2013	4,628		20	212	212	212	14
15	Water Main Upgrade	2013	14,950		20	498	498	498	15
16	Air Conditioner	2013	5,158		20	150	150	150	16
17	Furnish And Install New Tank Unit In Elevator	2013	9,870		20	206	206	206	17
18	Install Windos Throughout Whole Building	2013	224,726		20	7,491	7,491	7,491	18
19	Repipe Water Line	2013	3,200		20	160	160	160	19
20	Spray Fireproofing	2013	6,380		20	319	319	319	20
21	Wall Unit Air Conditioners	2013	7,993		20	400	400	400	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)		\$ 23,427,103	\$ 647,623		\$ 857,526	\$ 209,903	\$ 3,047,295	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 23,427,103	\$ 647,623		\$ 857,526	\$ 209,903	\$ 3,047,295	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)		\$ 23,427,103	\$ 647,623		\$ 857,526	\$ 209,903	\$ 3,047,295	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 Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 23,427,103	\$ 647,623		\$ 857,526	\$ 209,903	\$ 3,047,295		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)	\$ 23,427,103	\$ 647,623		\$ 857,526	\$ 209,903	\$ 3,047,295		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 Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Wallpaper/Installation	2009	18,410		20	1,811	1,811	9,055	9
10	Flooring	2009	44,832		20	2,242	2,242	8,968	10
11	Hand Rails/ Guards	2009	29,804		20	1,490	1,490	5,960	11
12	HVAC Upgrade	2010	306,200		20	15,310	15,310	61,240	12
13	Drapes, Cubicles, Coverlets	2010	166,306		20	8,597	8,597	34,388	13
14	Handrails	2010	59,608		20	2,980	2,980	11,921	14
15	Dialysis Room Piping	2010	19,324		20	966	966	3,864	15
16	Painting- 2nd Floor	2010	35,410		20	1,771	1,771	7,083	16
17	Painting- 4th Floor	2009	52,610		20	2,631	2,631	10,523	17
18	Pegasus- Nursing Stations	2009	165,000		20	8,250	8,250	33,000	18
19	Built In Furniture	2009	299,000		20	13,348	13,348	53,391	19
20	Flooring	2009	208,860		20	1,603	1,603	6,411	20
21	Flooring	2010	116,064		20	16,246	16,246	64,984	21
22	Window Treatments	2010	7,202		20	360	360	1,440	22
23	Corner Gaurds	2010	5,103		20	255	255	1,020	23
24	Flooring	2010	15,532		20	777	777	3,107	24
25	Telephone System	2010	42,428		20	2,121	2,121	11,555	25
26	Overbed Lights	2010	5,573		20	279	279	1,115	26
27	Overbed Lights	2010	9,240		20	462	462	1,848	27
28	Interior Signage	2010	5,424		20	271	271	1,084	28
29	Interior Signage	2010	4,305		20	215	215	861	29
30	Lighting	2010	26,692		20	1,335	1,335	5,339	30
31	Resident Room Locks	2010	6,990		20	350	350	1,399	31
32	1st Floor Resident Room Work	2011	4,500		20	225	225	675	32
33	PT Recovery Room	2011	4,000		20	200	200	710	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 Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2	Dialysis Water Purification	2011	6,385		20	319	319	957	2
3	Custom Cabinets	2011	4,000		20	200	200	600	3
4	Grocery Cabinets	2011	7,900		20	395	395	1,185	4
5	Carpet & Flooring	2011	3,717		20	186	186	558	5
6	Sprinkler Heads	2011	5,679		20	284	284	852	6
7	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	1,386	7
8	Elevator Flooring	2011	7,432		20	372	372	1,116	8
9	Sump Pump	2011	7,342		20	367	367	1,101	9
10	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	1,701	10
11	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	4,305	11
12	Cabinetry	2011	8,600		20	430	430	1,290	12
13	Elevator Panels	2011	9,000		20	450	450	1,350	13
14	Window Treatment	2011	11,587		20	579	579	1,737	14
15	Window Treatment	2011	19,302		20	965	965	2,895	15
16	Resident Flooring - 1st Floor	2011	25,357		20	1,268	1,268	3,804	16
17	Window Treatments	2011	3,003		20	150	150	450	17
18	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	1,059	18
19	Install Corner Guards	2011	3,840		20	192	192	576	19
20	Kitchen Dishwasher Install	2011	5,306		20	265	265	795	20
21	Fireproofing Rooms 201-202	2010	8,150		20	408	408	1,224	21
22	Family Room Wall Prep & Paint	2011	2,700		20	135	135	405	22
23	Check Valves, Sprayer, Faucet	2011	5,731		20	287	287	861	23
24	Sprinkler Heads	2011	9,299		20	465	465	1,395	24
25	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	975	25
26	2,3,4, Flr Bathrooms - Tiles, Walls, Flr	2011	190,991		20	9,550	9,550	28,650	26
27	Asbestos Handling	2011	441,394		20	22,070	22,070	66,210	27
28	Dialysis, Therapy, & Dining Rooms & 1st Flr & Basement Remodel	2011	5,662,788		20	283,139	283,139	849,639	28
29	Architect Fees-Dialysis, Therapy&Dining Rooms&1st Flr&Basement	2011	479,093		20	23,955	23,955	71,865	29
30	Fees Dialysis, Therapy & Dining Rooms & 1st Flr & Basement Remod	2011	299,630		20	14,982	14,982	44,946	30
31	Contracter Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & Baser	2011	36,491		20	1,825	1,825	5,475	31
32	Administrative Offices	2009	250,000		20	12,500	12,500	50,000	32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 9,235,970	\$		\$ 462,975	\$ 462,975	\$ 1,490,303	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated - S.I.R. Management</u>	2009	26,031		39	667	667	2,698	3
4	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1993	47,133	1,496	35	1,347	(149)	27,606	4
5									5
6									6
7									7
8	Leasehold Information								8
9	<u>Allocated - S.I.R. Management</u>	1993	11,950	333	20	102	(231)	11,950	9
10	<u>Allocated - S.I.R. Management</u>	1994	37		20			37	10
11	<u>Allocated - S.I.R. Management</u>	1995	273		20	14	14	251	11
12	<u>Allocated - S.I.R. Management</u>	1997	18,362	411	20	895	484	15,368	12
13	<u>Allocated - S.I.R. Management</u>	1999	1,444		20	72	72	1,028	13
14	<u>Allocated - S.I.R. Management</u>	2000	1,705		20	85	85	1,154	14
15	<u>Allocated - S.I.R. Management</u>	2007	5,477	374	20	274	(100)	1,696	15
16	<u>Allocated - S.I.R. Management</u>	2008	15,094	1,442	20	951	(491)	5,560	16
17	<u>Allocated - S.I.R. Management</u>	2009	37,506	343	20	1,875	1,532	7,960	17
18	<u>Allocated - S.I.R. Management</u>	2011	928	93	20	93		224	18
19	<u>Allocated - S.I.R. Management</u>	2012	2,969	148	20	148		209	19
20									20
21	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2012	2,887	398	20	20	(378)	23	21
22	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2010	2,844		20	142	142	474	22
23	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2009	2,830	126	20	142	16	679	23
24	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2007	825	65	20	41	(24)	289	24
25	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2002	187		20	9	9	108	25
26	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1999	5,972		20	299	299	4,330	26
27	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1998	2,854		20	143	143	2,212	27
28	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1997	178		20	9	9	155	28
29	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1994	449	12	20	22	10	437	29
30	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1993	764	4	20	19	15	764	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued		\$	\$		\$	\$	\$	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)		\$ 188,699	\$ 5,245		\$ 7,369	\$ 2,124	\$ 85,212	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,501,021	\$ 164,051	\$ 149,231	\$ (14,820)	10	\$ 561,055	71
72	Current Year Purchases	75,160		4,313	4,313	10	4,313	72
73	Fully Depreciated Assets	41,998		33	33	10	4,238	73
74								74
75	TOTALS	\$ 1,618,179	\$ 164,051	\$ 153,577	\$ (10,474)		\$ 569,606	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from S.I.R. Managemen	2013	\$ 3,660	\$ 383	\$ 437	\$ 54	5	\$ 1,718	76
77										77
78										78
79										79
80	TOTALS			\$ 3,660	\$ 383	\$ 437	\$ 54		\$ 1,718	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)	\$ 25,923,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 812,057	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,011,540	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 199,483	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,618,619	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	\$	\$	86
87	Land- Vacant Parcel - 2009	400,000			87
88	Land- Office Buidling - 2009	150,000			88
89					89
90					90
91	TOTALS	\$ 1,050,000	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect, Improv., FF&E	\$ 1,292,611	92
93	Resident Communication System	88,353	93
94			94
95		\$ 1,380,964	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

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning: 01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 13,468 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

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(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		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	362,233	\$		\$	362,233	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				165,354				165,354	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				490,058				490,058	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 prescrpts					356,790			356,790	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>							221,799			221,799	13
14	TOTAL			\$		\$	1,017,645	\$	578,589	\$	1,596,234	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 Ctr# 0049841Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 7,258	\$ 140,816	1
2	Cash-Patient Deposits	84,826	84,826	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,051,840	3,051,840	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,428	103,428	6
7	Other Prepaid Expenses	2,330	2,330	7
8	Accounts Receivable (owners or related parties)	130,000	303,122	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,379,682	\$ 3,686,362	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,500,000	13
14	Buildings, at Historical Cost		20,141,241	14
15	Leasehold Improvements, at Historical Cost	873,927	3,411,894	15
16	Equipment, at Historical Cost	523,086	1,614,042	16
17	Accumulated Depreciation (book methods)	(349,507)	(2,941,681)	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>	1,380,964	9,564,151	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,428,470	\$ 33,289,647	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,808,152	\$ 36,976,009	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 575,587	\$ 575,588	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	84,826	84,826	28
29	Short-Term Notes Payable	2,150,000	11,148,000	29
30	Accrued Salaries Payable	564,086	564,086	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,736	49,736	31
32	Accrued Real Estate Taxes(Sch.IX-B)		807,300	32
33	Accrued Interest Payable		92,723	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	215,309	1,525,042	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,639,544	\$ 14,847,301	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,633,408	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 19,633,408	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,639,544	\$ 34,480,709	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,168,608	\$ 2,495,300	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,808,152	\$ 36,976,009	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,357,889	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,357,889	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	578,719	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(768,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (189,281)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,168,608	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 17,637,086	1
2	Discounts and Allowances for all Levels	(4,502,857)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,134,229	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,123,674	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,123,674	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,125	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	332,271	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,064	19
20	Radiology and X-Ray	864	20
21	Other Medical Services	98,570	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 469,894	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,382	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,382	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	409,799	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 409,799	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,141,978	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,695,300	31
32	Health Care	5,288,656	32
33	General Administration	3,957,057	33
B. Capital Expense			
34	Ownership	3,230,639	34
C. Ancillary Expense			
35	Special Cost Centers	1,759,302	35
36	Provider Participation Fee	632,305	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,563,259	40
41	Income before Income Taxes (line 30 minus line 40)**	578,719	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 578,719	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,108,926	44
45	Private Pay - Net Inpatient Revenue	1,365,905	45
46	Medicare - Net Inpatient Revenue	1,061,910	46
47	Other-(specify) <u>Hospice</u>	581,490	47
48	Other-(specify) <u>HMO / Insurance</u>	15,998	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,134,229	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr

0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,933	2,086	\$ 105,259	\$ 50.46	1
2	Assistant Director of Nursing	1,941	2,086	75,556	36.22	2
3	Registered Nurses	43,527	46,903	1,309,550	27.92	3
4	Licensed Practical Nurses	32,254	34,421	773,761	22.48	4
5	CNAs & Orderlies	153,988	162,251	1,711,521	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,114	9,822	170,245	17.33	8
9	Activity Director	4,037	4,535	69,843	15.40	9
10	Activity Assistants	18,563	19,858	196,674	9.90	10
11	Social Service Workers	8,714	9,451	146,066	15.46	11
12	Dietician	3,869	4,047	78,695	19.45	12
13	Food Service Supervisor					13
14	Head Cook	7,554	8,101	102,302	12.63	14
15	Cook Helpers/Assistants	32,554	35,067	339,650	9.69	15
16	Dishwashers					16
17	Maintenance Workers	7,318	7,732	150,726	19.49	17
18	Housekeepers	33,872	36,174	346,320	9.57	18
19	Laundry	16,168	17,903	163,306	9.12	19
20	Administrator	3,779	4,171	181,768	43.58	20
21	Assistant Administrator	510	541	21,001	38.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,445	15,604	208,166	13.34	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	7,117	7,962	191,601	24.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,891	9,473	223,910	23.64	33
34	TOTAL (lines 1 - 33)	410,148	438,188	\$ 6,565,920 *	\$ 14.98	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	563	\$ 25,360	01-03	35
36	Medical Director	Monthly	44,400	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	86,400	10-03	38
39	Pharmacist Consultant	Monthly	17,522	10-03	39
40	Physical Therapy Consultant	20	993	10a-03	40
41	Occupational Therapy Consultant	3	170	10a-03	41
42	Respiratory Therapy Consultant	Monthly	844	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	76	3,795	11-03	44
45	Social Service Consultant	Monthly	11,775	12-03	45
46	Other(specify)				46
47	<u>Director of Food Service</u>	Monthly	36,000	01-03	47
48	<u>Dir. Of Specialized Services</u>	Monthly	28,800	10a-03	48
49	TOTAL (lines 35 - 48)	662	\$ 260,571		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Ctr# 0049841

Report Period Beginning:

01/01/13

Ending:

12/31/13**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. ILCLTC - \$24,453
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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. \$ 46,905 Line 10-02
- (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. \$ 632,305
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 34,164 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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.