

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0049841</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Regency Rehabilitation Center, Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>6631 Milwaukee Avenue</u> <u>Niles</u> <u>60714</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 647-7444</u> Fax # <u>(847) 647-6403</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>01/01/08</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Rehabilitation Center, Llc

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>67,865</u>	<u>9,642</u>	<u>14,570</u>	<u>92,077</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,865</u>	<u>9,642</u>	<u>14,570</u>	<u>92,077</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.86%

D. How many bed-hold days during this year were paid by the Department? 4 (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 10,832

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	509,381	125,780	60,133	695,294		695,294	(26,309)	668,985			1
2	Food Purchase		578,082		578,082	(32,281)	545,801	(602)	545,199			2
3	Housekeeping	305,821	87,929		393,750		393,750		393,750			3
4	Laundry	195,027	55,175		250,202		250,202		250,202			4
5	Heat and Other Utilities			269,218	269,218		269,218	8,466	277,684			5
6	Maintenance	161,244	75,410	362,447	599,101		599,101	(36,719)	562,382			6
7	Other (specify):*							5,950	5,950			7
8	TOTAL General Services	1,171,473	922,376	691,798	2,785,647	(32,281)	2,753,366	(49,214)	2,704,152			8
	B. Health Care and Programs											
9	Medical Director			39,600	39,600		39,600		39,600			9
10	Nursing and Medical Records	4,466,551	287,514	108,632	4,862,697		4,862,697	(54,200)	4,808,497			10
10a	Therapy	115,190		28,800	143,990		143,990	(14,942)	129,048			10a
11	Activities	260,172	16,925	1,446	278,543		278,543		278,543			11
12	Social Services	153,137		9,470	162,607		162,607		162,607			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,699	7,699			15
16	TOTAL Health Care and Programs	4,995,050	304,439	187,948	5,487,437		5,487,437	(61,443)	5,425,994			16
	C. General Administration											
17	Administrative	198,432		1,044,480	1,242,912		1,242,912	(899,208)	343,704			17
18	Directors Fees											18
19	Professional Services			292,373	292,373		292,373	(194,150)	98,223			19
20	Dues, Fees, Subscriptions & Promotions			128,734	128,734		128,734	(51,661)	77,073			20
21	Clerical & General Office Expenses	152,476	44,607	631,903	828,986		828,986	(353,764)	475,222			21
22	Employee Benefits & Payroll Taxes			1,587,595	1,587,595	32,281	1,619,876		1,619,876			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,460	5,460		5,460	508	5,968			24
25	Other Admin. Staff Transportation			2,918	2,918		2,918	13,291	16,209			25
26	Insurance-Prop.Liab.Malpractice			204,362	204,362		204,362	2,196	206,558			26
27	Other (specify):*							65,209	65,209			27
28	TOTAL General Administration	350,908	44,607	3,897,825	4,293,340	32,281	4,325,621	(1,417,579)	2,908,042			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,517,431	1,271,422	4,777,571	12,566,424		12,566,424	(1,528,236)	11,038,188			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			77,094	77,094		77,094	923,962	1,001,056			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,685	115,685		115,685	1,556,676	1,672,361			32
33	Real Estate Taxes							764,806	764,806			33
34	Rent-Facility & Grounds			3,060,000	3,060,000		3,060,000	(3,060,000)				34
35	Rent-Equipment & Vehicles			5,669	5,669		5,669	8,480	14,149			35
36	Other (specify):*							1	1			36
37	TOTAL Ownership			3,258,448	3,258,448		3,258,448	193,925	3,452,373			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,487,040	207,466	1,694,506		1,694,506		1,694,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			651,254	651,254		651,254		651,254			42
43	Other (specify):*	176,159			176,159		176,159	(176,159)				43
44	TOTAL Special Cost Centers	176,159	1,487,040	858,720	2,521,919		2,521,919	(176,159)	2,345,760			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,693,590	2,758,462	8,894,739	18,346,791		18,346,791	(1,510,469)	16,836,322			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,876)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	202,578	30		9
10	Interest and Other Investment Income	(19,186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(602)	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	(11,663)	21		18
19	Entertainment				19
20	Contributions	(1,750)	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	(449,342)	21		24
25	Fund Raising, Advertising and Promotional	(50,558)	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	(257,958)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (600,356)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(910,113)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (910,113)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,510,469)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					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

Report Period Beginning:

Ending:

ID#

0049841

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (175,959)	43	1
2	Collections	(8,886)	21	2
3	Bank Fees	(6,064)	21	3
4	Lobbying	(433)	21	4
5	Theft & Damage	(2,557)	21	5
6	State Replacement Tax	(8,700)	21	6
7	Additional R&M	4,152	06	7
8	Capitalized R&M	(6,799)	06	8
9	Marketing Bonus	(200)	43	9
10	Seminar Expense	(375)	24	10
11	Non-allowable legal	(6,057)	19	11
12	Office Expense - Bldg. Co	(39)	21	12
13	Amortization - Bldg. Co.	(44,958)	36	13
14	Professional Fees - Bldg. Co.	(1,083)	19	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
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(257,958)		49

ID#

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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			(720,000)	2
3	V	30	Depreciation Expense		6631 Milwaukee, LLC		708,885	708,885	3
4	V	36	Amortization Expense		6631 Milwaukee, LLC		44,959	44,959	4
5	V	32	Interest - LFB Loans		6631 Milwaukee, LLC		254,747	254,747	5
6	V	32	Interest Expense		6631 Milwaukee, LLC		1,322,999	1,322,999	6
7	V	21	Office Expense		6631 Milwaukee, LLC		39	39	7
8	V	19	Professional Fees		6631 Milwaukee, LLC		1,083	1,083	8
9	V	33	Real Estate Tax		6631 Milwaukee, LLC		759,862	759,862	9
10	V	06	Repairs	3,205	6631 Milwaukee, LLC		3,067	(138)	10
11	V	05	Utilities		6631 Milwaukee, LLC		5,193	5,193	11
12	V								12
13	V								13
14	Total			\$ 3,063,205			\$ 3,100,834	\$ * 37,629	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%	\$ 11,980	\$ (24,020)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	938	938	16
17	V	10	NURSING	86,400	S.I.R. MANAGEMENT, INC.	100.00%	21,489	(64,911)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,615	3,615	18
19	V	19	PROFESSIONAL FEES	226,800	S.I.R. MANAGEMENT, INC.	100.00%	17,553	(209,247)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	647	647	20
21	V	21	CLERICAL & GENERAL	86,400	S.I.R. MANAGEMENT, INC.	100.00%	81,964	(4,436)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	883	883	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	13,291	13,291	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,023	2,023	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,503	14,503	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(11,117)	(11,117)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	8,480	8,480	27
28	V								28
29	V	17	ADMINISTRATIVE	1,044,480	S.I.R. MANAGEMENT, INC.	100.00%	36,615	(1,007,865)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	302	302	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	138,217	138,217	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	27,013	27,013	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,480,080			\$ 368,396	\$ * (1,111,684)	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	1	DIETARY SALARIES	\$ 36,000	S.I.R. MANAGEMENT, INC.	100.00%	\$ 9,691	\$ (26,309)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,644	1,644	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	10,711	10,711	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,802	1,802	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	108,657	108,657	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	20,775	20,775	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	23,693	23,693	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,800	S.I.R. MANAGEMENT, INC.	100.00%	13,858	(14,942)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,282	2,282	25
26	V								26
27	V	6	MAINTENANCE SALARIES	17,319	S.I.R. MANAGEMENT, INC.	100.00%	18,520	1,201	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,368	3,368	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	3,273	3,273	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	761	761	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	77	77	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	100	100	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	173	173	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	12,499	12,499	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	9,233	9,233	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,944	4,944	37
38	V								38
39	Total			\$ 82,119			\$ 246,061	\$ * 163,942	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 374,223	\$ 374,223	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	374,223	CCS Employee Benefits Group	100.00%		(374,223)	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			\$ 374,223			\$ 374,223	\$ *	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	\$ 22,977	Long Term Care Laboratory, LLC	100.00%	\$ 22,977	\$	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			\$ 22,977			\$ 22,977	\$ *	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

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:	
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	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	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								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

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	N/A	See Attached	4.32	9.60%	Alloc. Salary	\$ 21,590	17-7	1
2	Kirsten Barrish	Relative	Clerical	N/A	See Attached	4.32	10.80%	Alloc. Salary	5,030	21-7	2
3	Sarah Barrish	Relative	Administrative	N/A	See Attached	5.4	10.80%	Alloc. Salary	13,055	17-7	3
4	Michael Giannini	Owner	Relative	N/A	See Attached	3.78	9.45%	Alloc. Salary	18,135	17-7	4
5	Nenita Guzman	Relative	Dietary	N/A	See Attached	5.4	10.80%	Alloc. Salary	9,691	1-7	5
6	Adam Vales	Relative	Clerical	N/A	See Attached	2.49	6.23%	Alloc. Salary	4,542	22-7	6
7	David Winter	Relative	Clerical	N/A	See Attached	0.7	10.77%	Alloc. Salary	365	21-7	7
8	Matthew Winter	Relative	Clerical	N/A	See Attached	0.17	10.63%	Alloc. Salary	93	21-7	8
9	Tom Winter	Owner	Administrative	1.56	See Attached	6.48	10.80%	Alloc. Salary	21,590	17-7	9
10	Bart Barrish	Relative	Administrative	N/A	See Attached	40	100.00%	Salary	6,131	17-1	10
11	Lori Barrish	Owner	Administrator	1.56	See Attached	40	100.00%	Salary	118,715	17-1	11
12	See second page 7 for the detail of the additional owner and related compensation										12
13								TOTAL	\$ 218,937		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

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	852,976	13	\$ 110,978	\$ 47,841	92,077	\$ 11,980	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		92,077	938	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	92,077	21,489	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		92,077	3,615	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	92,077	17,553	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		92,077	647	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	92,077	81,964	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		92,077	883	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		92,077	13,291	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		92,077	2,023	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		92,077	14,503	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		92,077	(11,117)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		92,077	8,480	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	92,077	36,615	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		92,077	302	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	92,077	138,217	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		92,077	27,013	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 368,396	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY SALARIES	PATIENT DAYS	852,976	13	\$ 89,778	\$ 89,778	92,077	\$ 9,691	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		92,077	1,644	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	92,077	10,711	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		92,077	1,802	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	92,077	108,657	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		92,077	20,775	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		92,077	23,693	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	28,800	13,858	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		28,800	2,282	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	17,319	18,520	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		17,319	3,368	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		1,390	3,273	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		1,390	761	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		1,390	77	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		1,390	100	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		1,390	173	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		1,390	12,499	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		1,390	9,233	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		1,390	4,944	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 246,061	25

Ending: 12/31/12

(847)905-4040

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Direct Allocation			\$	\$		\$ 22,977	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					\$	\$		\$ 22,977	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

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

Fax Number

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Ending: 12/31/12

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lake Forest Bank		X	Line of Credit			\$	2,350,000			\$	115,685	1
2	Mortgage Payable		X					20,039,722				1,322,999	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Member Loan - LFB		X					4,998,000				254,747	6
7	Member Loan		X					4,000,000					7
8	See Supplemental Schedule											9,233	8
9	TOTAL Facility Related						\$	31,387,722			\$	1,702,664	9
	B. Non-Facility Related*												
10	Interest Income		X									(19,186)	10
11	Alloc. S.I.R. Management	X										(11,117)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(30,303)	14
15	TOTALS (line 9+line14)						\$	31,387,722			\$	1,672,361	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$				\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Alloc. S.I.R. Management	X					\$				\$ 9,233	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital										9,233	14							
	B. Non-Facility Related*																		
15							\$				\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	735,000	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	749,806	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	14,806	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	750,000	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	764,806	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:		2007	552,631	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																							
		2008	604,679	9																						
		2009	683,760	10																						
		2010	665,529	11																						
		2011	744,862	12																						
2012 Accrual: \$744,862 X 1.01 = \$750,000 (Rounded)																										
Allocation from S.I.R. Management = \$4,944																										
Beginning Accrual Adjusted																										

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>10-31-401-046-0000</u>	<u>Long Term Care Property</u>	\$ <u>744,861.57</u>	\$ <u>744,861.57</u>
2.	<u>See Attached</u>	<u>Home office Allocation</u>	\$ <u>101,165.17</u>	\$ <u>8,550.90</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>846,026.74</u></u>	\$ <u><u>753,412.47</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

FACILITY NAME Regency Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

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.)

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.

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	Facility		2009	\$ 875,000	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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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)	\$ 943,955	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	252,676		20	14,792	14,792	67,813	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

Facility Name & ID Number Regency Rehabilitation Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		9,235,970			462,975	462,975	19,275,503	67
68	Related Party Allocations (Pages 12H & 12I)		195,591	6,580		8,077	1,497	80,707	68
69	Financial Statement Depreciation			77,094			(77,094)		69
70	TOTAL (lines 4 thru 69)		\$ 22,584,237	\$ 631,161		\$ 816,613	\$ 185,452	\$ 20,367,978	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 Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 22,584,237	\$ 631,161		\$ 816,613	\$ 185,452	\$ 20,367,978	1
2	Shower Faucets	2009	12,940		20	647	647	2,588	2
3	Ejector Pump	2009	6,242		20	312	312	1,144	3
4	Fire Dampers	2009	5,986		20	299	299	1,097	4
5	Fire Dampers	2009	3,246		20	162	162	595	5
6	Security System	2009	2,825		20	283	283	989	6
7	Door Alarms	2009	5,697		20	570	570	1,994	7
8	Ductwork	2009	13,130		20	657	657	2,188	8
9	Plumbing Work	2009	3,450		20	173	173	561	9
10	Roof	2009	87,084		20	4,354	4,354	14,151	10
11	Window Treatments	2009	3,458		20	173	173	692	11
12	Hot Water Work	2009	3,077		20	154	154	603	12
13	Condenser	2009	11,395		20	570	570	2,184	13
14	Rooftop Hvac Fans	2009	20,668		20	1,033	1,033	3,961	14
15	Dryer Vent/Exhaust	2009	14,755		20	738	738	2,705	15
16	Storm Drain Pipe Repair	2009	5,800		20	290	290	1,015	16
17	Exhaust Fan & Dampers	2009	9,809		20	490	490	1,717	17
18	Stats & Pneumatic Tubing	2009	4,276		20	214	214	766	18
19	Hvac Controller	2009	5,720		20	286	286	1,025	19
20	Extending Ductwork	2009	3,593		20	180	180	614	20
21	Boiler Repair	2009	5,323		20	266	266	865	21
22	Chiller Repair	2009	4,526		20	226	226	830	22
23	Sprinkler Heads	2009	6,000		20	300	300	1,150	23
24	Fire Alarm Repair	2009	2,994		20	150	150	549	24
25	Replace Smoke Damper	2009	2,887		20	144	144	529	25
26	Sprinkler System Repair	2009	3,433		20	172	172	586	26
27	Dryer Exhaust	2010	29,940		20	1,497	1,497	4,117	27
28	Hvac Work	2010	2,985		20	299	299	647	28
29	Nurse Call System	2010	3,078		20	308	308	667	29
30	Exit Doors	2010	4,780		20	239	239	558	30
31	Elevator Work	2010	3,126		20	156	156	443	31
32	Carpet Installation	2010	3,981		20	199	199	531	32
33	Sprinkler Work	2010	3,965		20	198	198	578	33
34	TOTAL (lines 1 thru 33)		\$ 22,884,406	\$ 631,161		\$ 832,350	\$ 201,189	\$ 20,420,616	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Rehabilitation Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 22,884,406	\$ 631,161		\$ 832,350	\$ 201,189	\$ 20,420,616	1
2	Elevator Renovations	2010	4,689		20	234	234	488	2
3	Laminate Panels, Hand Rails, Coffe Ceilings	2010	9,000		20	450	450	938	3
4	Flooring	2010	5,634		20	282	282	587	4
5	Fire System Tank	2011	2,985		20	149	149	299	5
6	Security Camera System	2011	7,967		20	1,593	1,593	2,921	6
7	Hvac- Coil Replacement	2011	12,168		20	608	608	1,014	7
8	Fire System- Sensor Modules	2011	3,064		20	153	153	255	8
9	Security Camera System	2011	8,612		20	1,722	1,722	3,014	9
10	Elevator Motor Work	2011	9,175		20	459	459	726	10
11	Elevator Door Operator	2011	8,547		20	427	427	641	11
12	Overbed Lights (24)	2011	2,330		20	233	233	330	12
13	Magnetic Door Closers	2011	7,474		20	374	374	498	13
14	Fire Pump Work	2011	3,225		20	161	161	215	14
15	Fire Alarm System Work	2011	4,641		20	232	232	290	15
16	Fire Doors	2011	3,300		20	165	165	193	16
17	Closet Soffit	2011	6,497		20	325	325	568	17
18	Prep/Paint 16 Rooms	2011	6,784		20	339	339	707	18
19	Water Purification System	2011	3,831		20	192	192	399	19
20	Repair Air Handler	2011	3,941		20	197	197	361	20
21	Replace Belts & Exhaust Fans	2011	15,623		20	781	781	1,367	21
22	Elevator Work	2011	3,778		20	189	189	346	22
23	Replace Valves	2011	3,190		20	160	160	279	23
24	Repair Coil	2011	2,795		20	140	140	280	24
25	Replace Control & Valve	2011	8,491		20	425	425	849	25
26	Protective Bumpers	2012	4,200		20	420	420	420	26
27	Boiler Work	2012	10,499		20	525	525	525	27
28	Boiler Work	2012	9,418		20	392	392	392	28
29	Boiler Work	2012	4,109		20	137	137	137	29
30	Fire Panel Work	2012	3,982		20	116	116	116	30
31	Ceiling Fan Insulation	2012	11,185		20	280	280	280	31
32	Privacy Curtains	2012	3,034		20	25	25	25	32
33	Tuckpointing	2012	12,000		20	100	100	100	33
34	TOTAL (lines 1 thru 33)		\$ 23,090,573	\$ 631,161		\$ 844,336	\$ 213,175	\$ 20,440,177	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	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		\$ 23,090,573	\$ 631,161		\$ 844,336	\$ 213,175	\$ 20,440,177	1
2 Compressor	2012	5,348		20	22	22	22	2
3 Tuckpointing & Caulking	2012	49,045		20	204	204	204	3
4 Handrails	2012	5,325		20	178	178	178	4
5 Installed Piping In Two Showers	2012	3,981		20	199	199	199	5
6 Monitor Modules Floors 1,2,3 &4	2012	2,818		20	141	141	141	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)		\$ 23,157,090	\$ 631,161		\$ 845,080	\$ 213,919	\$ 20,440,921	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 23,157,090	\$ 631,161		\$ 845,080	\$ 213,919	\$ 20,440,921	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)		\$ 23,157,090	\$ 631,161		\$ 845,080	\$ 213,919	\$ 20,440,921	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Rehabilitation Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	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	7,244	9
10	Flooring	2009	44,832		20	2,242	2,242	6,726	10
11	Hand Rails/ Guards	2009	29,804		20	1,490	1,490	4,470	11
12	HVAC Upgrade	2010	306,200		20	15,310	15,310	45,930	12
13	Drapes, Cubicles, Coverlets	2010	166,306		20	8,597	8,597	25,791	13
14	Handrails	2010	59,608		20	2,980	2,980	8,941	14
15	Dialysis Room Piping	2010	19,324		20	966	966	2,898	15
16	Painting- 2nd Floor	2010	35,410		20	1,771	1,771	5,312	16
17	Painting- 4th Floor	2009	52,610		20	2,631	2,631	7,892	17
18	Pegasus- Nursing Stations	2009	165,000		20	8,250	8,250	24,750	18
19	Built In Furniture	2009	299,000		20	13,348	13,348	40,043	19
20	Flooring	2009	208,860		20	1,603	1,603	4,808	20
21	Flooring	2010	116,064		20	16,246	16,246	48,738	21
22	Window Treatments	2010	7,202		20	360	360	1,080	22
23	Corner Gaurds	2010	5,103		20	255	255	765	23
24	Flooring	2010	15,532		20	777	777	2,330	24
25	Telephone System	2010	42,428		20	2,121	2,121	9,434	25
26	Overbed Lights	2010	5,573		20	279	279	836	26
27	Overbed Lights	2010	9,240		20	462	462	1,386	27
28	Interior Signage	2010	5,424		20	271	271	813	28
29	Interior Signage	2010	4,305		20	215	215	646	29
30	Lighting	2010	26,692		20	1,335	1,335	4,004	30
31	Resident Room Locks	2010	6,990		20	350	350	1,049	31
32	1st Floor Resident Room Work	2011	4,500		20	225	225	450	32
33	PT Recovery Room	2011	4,000		20	200	200	510	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Rehabilitation Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 Continued		\$	\$		\$	\$	\$	1
2	Dialysis Water Purification	2011	6,385		20	319	319	638	2
3	Custom Cabinets	2011	4,000		20	200	200	400	3
4	Grocery Cabinets	2011	7,900		20	395	395	790	4
5	Carpet & Flooring	2011	3,717		20	186	186	372	5
6	Sprinkler Heads	2011	5,679		20	284	284	568	6
7	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	924	7
8	Elevator Flooring	2011	7,432		20	372	372	744	8
9	Sump Pump	2011	7,342		20	367	367	734	9
10	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	1,134	10
11	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	2,870	11
12	Cabinetry	2011	8,600		20	430	430	860	12
13	Elevator Panels	2011	9,000		20	450	450	900	13
14	Window Treatment	2011	11,587		20	579	579	1,158	14
15	Window Treatment	2011	19,302		20	965	965	1,930	15
16	Resident Flooring - 1st Floor	2011	25,357		20	1,268	1,268	2,536	16
17	Window Treatments	2011	3,003		20	150	150	300	17
18	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	706	18
19	Install Corner Guards	2011	3,840		20	192	192	384	19
20	Kitchen Dishwasher Install	2011	5,306		20	265	265	530	20
21	Fireproofing Rooms 201-202	2010	8,150		20	408	408	816	21
22	Family Room Wall Prep & Paint	2011	2,700		20	135	135	270	22
23	Check Valves, Sprayer, Faucet	2011	5,731		20	287	287	574	23
24	Sprinkler Heads	2011	9,299		20	465	465	930	24
25	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	650	25
26	2,3,4, Flr Bathrooms - Tiles, Walls, Flr	2011	190,991		20	9,550	9,550	19,100	26
27	Asbestos Handling	2011	441,394		20	22,070	22,070	44,140	27
28	Dialysis, Therapy, & Dining Rooms & 1st Flr & Basement Remodel	2011	5,662,788		20	283,139	283,139	566,500	28
29	Architect Fees-Dialysis, Therapy&Dining Rooms&1st Flr&Basement	2011	479,093		20	23,955	23,955	47,910	29
30	Fees Dialysis, Therapy & Dining Rooms & 1st Flr & Basement Remo	2011	299,630		20	14,982	14,982	29,964	30
31	Contracter Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & Base	2011	36,491		20	1,825	1,825	18,251,825	31
32	Administrative Offices	2009	250,000		20	12,500	12,500	37,500	32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 9,235,970	\$		\$ 462,975	\$ 462,975	\$ 19,275,503	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Regency Rehabilitation Center, Llc

0049841

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated - S.I.R. Management</u>	2009	26,982		39	692	692	2,104	3
4	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1993	48,855	1,551	35	1,396	(155)	27,219	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated - S.I.R. Management</u>	1993	12,386	345	20	614	269	12,281	9
10	<u>Allocated - S.I.R. Management</u>	1994	39		20			39	10
11	<u>Allocated - S.I.R. Management</u>	1995	283		20	14	14	247	11
12	<u>Allocated - S.I.R. Management</u>	1997	19,032	426	20	934	508	15,008	12
13	<u>Allocated - S.I.R. Management</u>	1999	1,496		20	75	75	991	13
14	<u>Allocated - S.I.R. Management</u>	2000	1,767		20	88	88	1,108	14
15	<u>Allocated - S.I.R. Management</u>	2007	5,677	387	20	284	(103)	1,474	15
16	<u>Allocated - S.I.R. Management</u>	2008	15,645	1,495	20	986	(509)	4,777	16
17	<u>Allocated - S.I.R. Management</u>	2009	38,876	356	20	1,944	1,588	6,307	17
18	<u>Allocated - S.I.R. Management</u>	2011	962	96	20	96		136	18
19	<u>Allocated - S.I.R. Management</u>	2012	3,078	64	20	64		64	19
20									20
21	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2012	2,993	1,592	20	13	(1,579)	13	21
22	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2010	2,948		20	147	147	344	22
23	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2009	2,933	183	20	147	(36)	557	23
24	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2007	855	69	20	43	(26)	257	24
25	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	2002	194		20	10	10	102	25
26	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1999	6,191		20	310	310	4,179	26
27	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1998	2,958		20	148	148	2,145	27
28	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1997	184		20	9	9	152	28
29	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1994	465	12	20	23	11	430	29
30	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1993	792	4	20	40	36	773	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		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)		\$ 195,591	\$ 6,580		\$ 8,077	\$ 1,497	\$ 80,707	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	\$ 1,472,912	\$ 166,562	\$ 153,388	\$ (13,174)	10	\$ 411,676	71
72	Current Year Purchases	31,929	218	2,013	1,795	10	2,013	72
73	Fully Depreciated Assets	42,869				10	42,869	73
74								74
75	TOTALS	\$ 1,547,710	\$ 166,780	\$ 155,401	\$ (11,379)		\$ 456,558	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. Managemer	2011	\$ 3,794	\$ 537	\$ 575	\$ 38	5	\$ 1,327	76
77										77
78										78
79										79
80	TOTALS			\$ 3,794	\$ 537	\$ 575	\$ 38		\$ 1,327	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 25,583,594	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 798,478	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,001,056	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 202,578	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 20,898,807	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	Lawrence Kahn	\$ 1,292,611	92
93	Window Installation	118,815	93
94	Inteliplex Communication	68,719	94
95		\$ 1,480,145	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 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

**

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: \$ 14,149 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 68,424	\$		\$ 68,424	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,214			18,214	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			120,828	848,547		969,375	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				357,778		357,778	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						280,715		280,715	13
14	TOTAL			\$		\$ 207,466	\$ 1,487,040		\$ 1,694,506	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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 124,280	\$ 279,049	1
2	Cash-Patient Deposits	109,897	109,897	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,522,605	3,522,605	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	164,329	164,329	6
7	Other Prepaid Expenses	72,422	72,422	7
8	Accounts Receivable (owners or related parties)		74,000	8
9	Other(specify): See Attached Schedule	16,000	16,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,009,533	\$ 4,238,302	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	614,595	3,152,562	15
16	Equipment, at Historical Cost	443,995	1,534,951	16
17	Accumulated Depreciation (book methods)	(254,616)	(2,118,676)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,480,145	9,589,644	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,284,119	\$ 33,799,722	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,293,652	\$ 38,038,024	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 538,997	\$ 538,998	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	109,897	109,897	28
29	Short-Term Notes Payable	2,350,000	11,348,000	29
30	Accrued Salaries Payable	536,533	536,533	30
31	Accrued Taxes Payable (excluding real estate taxes)	50,710	50,710	31
32	Accrued Real Estate Taxes(Sch.IX-B)		750,000	32
33	Accrued Interest Payable		93,852	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	349,626	1,659,359	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,935,763	\$ 15,087,349	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		20,039,722	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 20,039,722	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,935,763	\$ 35,127,071	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,357,889	\$ 2,910,953	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,293,652	\$ 38,038,024	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,199,225	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,199,228	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,086,661	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	(928,000)	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)	\$ 158,661	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)	\$ 2,357,889	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$19,271,992	1
2	Discounts and Allowances for all Levels	(4,219,462)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$15,052,530	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,838,120	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$3,838,120	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	1,375	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	324,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,782	19
20	Radiology and X-Ray	999	20
21	Other Medical Services	165,095	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$522,504	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,186	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$19,186	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,112	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$1,112	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$19,433,452	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,785,647	31
32	Health Care	5,487,437	32
33	General Administration	4,293,340	33
	B. Capital Expense		
34	Ownership	3,258,448	34
	C. Ancillary Expense		
35	Special Cost Centers	1,870,665	35
36	Provider Participation Fee	651,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$18,346,791	40
41	Income before Income Taxes (line 30 minus line 40)**	1,086,661	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$1,086,661	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$10,807,826	44
45	Private Pay - Net Inpatient Revenue	1,889,278	45
46	Medicare - Net Inpatient Revenue	1,840,329	46
47	Other-(specify) Hospice	450,902	47
48	Other-(specify) HMO/Insurance/Veteran	64,195	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$15,052,530	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.

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	1,931	2,163	\$ 104,793	\$ 48.45	1
2	Assistant Director of Nursing	2,002	2,193	79,425	36.22	2
3	Registered Nurses	58,779	62,058	1,583,313	25.51	3
4	Licensed Practical Nurses	32,018	33,743	808,566	23.96	4
5	CNAs & Orderlies	164,210	173,227	1,828,997	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,222	6,866	115,190	16.78	8
9	Activity Director	4,256	4,539	68,720	15.14	9
10	Activity Assistants	17,914	18,909	191,452	10.12	10
11	Social Service Workers	8,995	9,615	153,137	15.93	11
12	Dietician	3,642	3,952	78,921	19.97	12
13	Food Service Supervisor			150		13
14	Head Cook	6,995	7,397	92,376	12.49	14
15	Cook Helpers/Assistants	33,853	36,605	337,934	9.23	15
16	Dishwashers					16
17	Maintenance Workers	7,541	8,402	161,244	19.19	17
18	Housekeepers	31,107	33,798	305,821	9.05	18
19	Laundry	19,421	21,073	195,027	9.25	19
20	Administrator	2,069	2,263	124,746	55.12	20
21	Assistant Administrator	1,986	2,091	73,686	35.24	21
22	Other Administrative	6,999	7,602			22
23	Office Manager					23
24	Clerical	10,194	11,074	152,476	13.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	8,969	9,693	237,616	24.51	33
34	TOTAL (lines 1 - 33)	429,103	457,263	\$ 6,693,590 *	\$ 14.64	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	526	\$ 24,133	01-03	35
36	Medical Director	Monthly	39,600	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	17,720	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,446	11-03	44
45	Social Service Consultant	Monthly	9,470	12-03	45
46	Other(specify)				46
47	Director of Food Service	Monthly	36,000	01-03	47
48	Dir. Of Specialized Services	Monthly	28,800	10a-03	48
49	TOTAL (lines 35 - 48)	555	\$ 248,081		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Lori Barrish	Administrator	1.56%	\$ 118,715	Workers' Compensation Insurance		\$ 220,072	IDPH License Fee		\$ 1,992		
Bart Barrish	Administrator	0.00%	6,131	Unemployment Compensation Insurance		166,590	Advertising: Employee Recruitment		33,798		
Barbara Dabrowski	Asst. Admin	0.00%	73,586	FICA Taxes		511,820	Health Care Worker Background Check		7,894		
				Employee Health Insurance		630,161	(Indicate # of checks performed 789)				
				Employee Meals		32,281	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			ICLTC		22,743		
				401K Contributions		5,085	Dues & Subscriptions		4,868		
				Other Employee Benefits		15,316	License & Permits		5,131		
				Workers Comp. Audit		38,551	Allocated from S.I.R. Management		647		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
</											

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

****See instructions.**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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

XX. GENERAL INFORMATION:

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

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$22,743.00

(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.

\$24,067

Line10

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$651,254

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$32,281

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 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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT