FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0049841

Facility Name: Regency Rehabilitation Ctr

Address: 6631 Milwaukee Ave (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: (847) 647-7444 **Fax #** (847) 647-6403

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2008

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	57,794	6,290	19,720	83,804	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,794	6,290	19,720	83,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.53%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 300 and days of care provided 11,836

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/204 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	538,746	95,882	58,560	693,188		693,188	(27,785)	665,403			1
2	Food Purchase		580,440		580,440	(35,314)	545,126	(433)	544,693			2
3	Housekeeping	347,720	86,814		434,534		434,534		434,534			3
4	Laundry	165,505	60,915		226,420		226,420		226,420			4
5	Heat and Other Utilities			335,461	335,461		335,461	(7,131)	328,330			5
6	Maintenance	151,963	78,326	247,519	477,808		477,808	(13,177)	464,631			6
7	Other (specify):*							6,779	6,779			7
8	TOTAL General Services	1,203,934	902,377	641,540	2,747,851	(35,314)	2,712,537	(41,747)	2,670,791			8
	B. Health Care and Programs											
9	Medical Director			50,400	50,400		50,400		50,400			9
10	Nursing and Medical Records	4,534,719	252,861	111,122	4,898,702		4,898,702	(39,623)	4,859,079			10
10a	Therapy	137,284		37,039	174,323		174,323	(14,794)	159,529			10a
11	Activities	248,433	11,937	5,139	265,509		265,509		265,509			11
12	Social Services	165,889		6,298	172,187		172,187		172,187			12
13	CNA Training											13
14	Program Transportation			765	765		765		765			14
15	Other (specify):*							8,719	8,719			15
16	TOTAL Health Care and Programs	5,086,325	264,798	210,763	5,561,886		5,561,886	(45,698)	5,516,188			16
	C. General Administration											
17	Administrative	212,336		1,030,238	1,242,574		1,242,574	(877,475)	365,099			17
18	Directors Fees											18
19	Professional Services			312,353	312,353	(53,901)	258,452	(126,302)	132,150			19
20	Dues, Fees, Subscriptions & Promotions			138,236	138,236		138,236	(48,269)	89,967			20
21	Clerical & General Office Expenses	214,916	38,611	579,876	833,403		833,403	(329,864)	503,539			21
22	Employee Benefits & Payroll Taxes			1,402,736	1,402,736	35,314	1,438,050		1,438,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,298	5,298		5,298	735	6,033			24
25	Other Admin. Staff Transportation			3,465	3,465		3,465	14,328	17,793			25
26	Insurance-Prop.Liab.Malpractice			241,155	241,155		241,155	3,192	244,347			26
27	Other (specify):*							59,028	59,028			27
28	TOTAL General Administration	427,252	38,611	3,713,357	4,179,220	(18,587)	4,160,633	(1,304,626)	2,856,007			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,717,511	1,205,786	4,565,660	12,488,957	(53,901)	12,435,056	(1,392,071)	11,042,985			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Regency Rehabilitation Ctr #0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			156,559	156,559		156,559	878,363	1,034,922			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,356	100,356		100,356	1,238,390	1,338,746			32
33	Real Estate Taxes					53,901	53,901	916,177	970,078			33
34	Rent-Facility & Grounds			3,060,000	3,060,000		3,060,000	(3,060,000)				34
35	Rent-Equipment & Vehicles			5,726	5,726		5,726	9,135	14,861			35
36	Other (specify):*							84,641	84,641			36
37	**TOTAL Ownership**			3,322,641	3,322,641	53,901	3,376,542	66,706	3,443,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		703,870	1,378,471	2,082,341		2,082,341		2,082,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			620,207	620,207		620,207		620,207			42
43	Other (specify):*	169,862			169,862		169,862	(169,862)				43
44	**TOTAL Special Cost Centers**	169,862	703,870	1,998,678	2,872,410		2,872,410	(169,862)	2,702,548			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,887,373	1,909,656	9,886,979	18,684,008		18,684,008	(1,495,227)	17,188,781			45

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(13,223)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	183,554	30		9
10	Interest and Other Investment Income	(1,733)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(433)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,649)	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	(428,948)	21		24
25	Fund Raising, Advertising and Promotional	(36,670)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(241,048)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (556,651)		$	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)	(938,576)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (938,576)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,495,227)		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

STATE OF ILLINOIS **Page 5A**

Regency Rehabilitation Ctr

ID# **0049841**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (169,862)	43	1
2	Legal Fees - Collections	(10,756)	21	2
3	Bank Fees	(6,355)	21	3
4	Theft & Damage	(1,733)	21	4
5	Additional R&M	3,905	06	5
6	Non Allowable Legal Fees	(362)	19	6
7	2015 Seminar	(420)	24	7
8	PAC Dues	(8,069)	20	8
9	Bldg Co. - Amortization	(37,243)	36	9
10	Bldg Co. - Office Expense	(495)	21	10
11	Capitalized R&M	(9,659)	06	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(241,048)		49

Regency Rehabilitation Ctr

ID# 0049841

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(27,785)								(27,785)	1
2	Food Purchase	(433)											(433)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,223)	3,285		2,807								(7,131)	5
6	Maintenance	(5,754)	1,828	(20,328)	11,077								(13,177)	6
7	Other (specify):*			983	5,796								6,779	7
8	**TOTAL General Services**	(19,410)	5,113	(19,345)	(8,105)								(41,747)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(50,991)	11,368								(39,623)	10
10a	Therapy				(14,794)								(14,794)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,007	3,712								8,719	15
16	**TOTAL Health Care and Programs**			(45,984)	286								(45,698)	16
	C. General Administration													
17	Administrative			(992,458)	114,983								(877,475)	17
18	Directors Fees													18
19	Professional Services	(362)	52,915	(201,907)	23,052								(126,302)	19
20	Fees, Subscriptions & Promotions	(52,388)		4,119									(48,269)	20
21	Clerical & General Office Expenses	(458,787)	495	128,327	101								(329,864)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(420)		1,155									735	24
25	Other Admin. Staff Transportation			14,328									14,328	25
26	Insurance-Prop.Liab.Malpractice			2,991	201								3,192	26
27	Other (specify):*			35,286	23,742								59,028	27
28	**TOTAL General Administration**	(511,956)	53,410	(1,008,159)	162,079								(1,304,626)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(531,366)	58,523	(1,073,488)	154,260								(1,392,071)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Rehabilitation Ctr **#** 0049841 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	183,554	686,635		8,174								878,363	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,733)	1,259,728	(28,495)	8,890								1,238,390	32
33	Real Estate Taxes		905,461		10,716								916,177	33
34	Rent-Facility & Grounds		(3,060,000)										(3,060,000)	34
35	Rent-Equipment & Vehicles			9,135									9,135	35
36	Other (specify):*	(37,243)	121,884										84,641	36
37	**TOTAL Ownership**	144,578	(86,292)	(19,360)	27,780								66,706	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(169,862)											(169,862)	43
44	**TOTAL Special Cost Centers**	(169,862)											(169,862)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(556,651)	(27,769)	(1,092,848)	182,040								(1,495,227)	45

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 3,060,000	6631 N. Milwaukee, LLC	100.00%	$	$ (3,060,000)	1
2	V	30	Depreciation - SNF		6631 N. Milwaukee, LLC	100.00%	686,635	686,635	2
3	V	36	Amortization		6631 N. Milwaukee, LLC	100.00%	37,243	37,243	3
4	V	32	Interest - LFB Loans		6631 N. Milwaukee, LLC	100.00%	147,253	147,253	4
5	V	32	Interest Expense		6631 N. Milwaukee, LLC	100.00%	1,112,475	1,112,475	5
6	V	36	Mortgage Insurance		6631 N. Milwaukee, LLC	100.00%	84,641	84,641	6
7	V	21	Office Expense		6631 N. Milwaukee, LLC	100.00%	495	495	7
8	V	33	Real Estate Taxes		6631 N. Milwaukee, LLC	100.00%	905,461	905,461	8
9	V	06	Repairs		6631 N. Milwaukee, LLC	100.00%	1,828	1,828	9
10	V	05	Utility		6631 N. Milwaukee, LLC	100.00%	3,285	3,285	10
11	V		RE Tax Refund	209,663	6631 N. Milwaukee, LLC	100.00%		(209,663)	11
12	V	19	RE Legal Fees		6631 N. Milwaukee, LLC	100.00%	52,915	52,915	12
13	V								13
14	Total			$ 3,269,663			$ 3,032,231	$ * (237,432)	14

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 36,000	S.I.R. MANAGEMENT, INC.	100.00%	$ 15,672	$ (20,328)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	983	983	16
17	V	10	NURSING	86,400	S.I.R. MANAGEMENT, INC.	100.00%	35,409	(50,991)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	5,007	5,007	18
19	V	19	PROFESSIONAL FEES	226,800	S.I.R. MANAGEMENT, INC.	100.00%	14,844	(211,956)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	4,119	4,119	20
21	V	21	CLERICAL & GENERAL	86,400	S.I.R. MANAGEMENT, INC.	100.00%	65,954	(20,446)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,155	1,155	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	14,328	14,328	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,991	2,991	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,402	10,402	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(28,495)	(28,495)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,599	7,599	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,536	1,536	28
29	V								29
30	V	17	ADMINISTRATIVE	1,030,238	S.I.R. MANAGEMENT, INC.	100.00%	37,780	(992,458)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	10,049	10,049	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	148,773	148,773	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	24,884	24,884	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,465,838			$ 372,990	$ * (1,092,848)	39

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 36,000	S.I.R. MANAGEMENT, INC.	100.00%	$ 8,215	$ (27,785)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,212	1,212	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	11,368	11,368	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,620	1,620	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	114,983	114,983	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	21,962	21,962	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	23,742	23,742	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,800	S.I.R. MANAGEMENT, INC.	100.00%	14,006	(14,794)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,092	2,092	25
26	V								26
27	V	6	MAINTENANCE SALARIES	20,436	S.I.R. MANAGEMENT, INC.	100.00%	29,308	8,872	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,584	4,584	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,807	2,807	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	2,205	2,205	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,090	1,090	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	101	101	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	201	201	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,174	8,174	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	8,890	8,890	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	10,716	10,716	37
38	V								38
39	Total			$ 85,236			$ 267,276	$ * 182,040	39

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary	$ 38,633	Long Term Care Laboratory, LLC	100.00%	$ 38,633	$	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			$ 38,633			$ 38,633	$ *	39

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	LORI BARRISH	1.563%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	MICHAEL GIANNINI TRUST	10.417%	GREENWOOD CARE, INC.	EVANSTON				7
8	RALPH GESULADO	12.153%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	RALPH GESULADO CHILDREN'S TRUST	12.153%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				9
10	THOMAS WINTER	1.563%	WILSON CARE, INC.	CHICAGO				10
11			WESLEY REHABILITATION CENTER	AUBURN, IN				11
12			OAKTON PAVILION	DES PLAINES				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 Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Giannini	Relative	Administrative	0%	See Attached	3.90	9.75%	Alloc. Salary	$ 18,614	17-07	1
2	Tom Winter	Owner	Administrative	1.56%	See Attached	6.69	11.15%	Alloc. Salary	22,302	17-07	2
3	Lori Barrish	Owner	Administrator	1.56%	See Attached	27.50	50.00%	Salary	60,270	17-01	3
4	Bryan Barrish	Relative	Administrative	0%	See Attached	4.46	9.91%	Alloc. Salary	22,302	17-07	4
5	Sarah Barrish	Relative	Administrative	0%	See Attached	5.02	11.16%	Alloc. Salary	13,567	17-07	5
6	Bart Barrish	Relative	Administrative	0%	See Attached	26.67	66.68%	Salary	49,080	17-01	6
7	Kirsten Barrish	Relative	Clerical	0%	See Attached	5.58	11.16%	Alloc. Salary	10,287	21-07	7
8	Nenita Guzman	Relative	Dietary	0%	See Attached	5.58	11.16%	Alloc. Salary	8,215	01-07	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 204,637		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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 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	6	REPAIRS AND MAINT.	PATIENT DAYS	751,530	16	$ 140,542	$ 58,090	83,804	$ 15,672	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		83,804	983	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	83,804	35,409	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		83,804	5,007	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	83,804	14,844	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		83,804	4,119	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	83,804	65,954	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		83,804	1,155	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		83,804	14,328	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		83,804	2,991	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		83,804	10,402	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		83,804	(28,495)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		83,804	7,599	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		83,804	1,536	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	83,804	37,780	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		83,804	10,049	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	83,804	148,773	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		83,804	24,884	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 372,990	25

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 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	DIETARY SALARIES	PATIENT DAYS	751,530	16	$ 73,669	$ 73,669	83,804	$ 8,215	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		83,804	1,212	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	83,804	11,368	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		83,804	1,620	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	83,804	114,983	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		83,804	21,962	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		83,804	23,742	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	28,800	14,006	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		28,800	2,092	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	20,436	29,308	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		20,436	4,584	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		1,436	2,807	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		1,436	2,205	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		1,436	1,090	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		1,436	101	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		1,436	201	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		1,436	8,174	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		1,436	8,890	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		1,436	10,716	23
24										24
25	TOTALS					$ 2,757,483	$ 1,907,027		$ 267,276	25

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 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			$	$		$ 38,633	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					$	$		$ 38,633	25

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Mortgage Payable		X				$	$ 25,587,000			$ 1,112,475	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				2,950,000			100,356	6
7	Lake Forest Bank		X	Member Loan				3,300,000			147,253	7
8	See Supplemental Schedule										8,890	8
9	TOTAL Facility Related						$	$ 31,837,000			$ 1,368,974	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,733)	10
11	Allocated from SIR Managemer	X									(28,495)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (30,228)	14
15	TOTALS (line 9+line14)						$	$ 31,837,000			$ 1,338,746	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 84,641 Line # 36

* 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.)

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	Allocated from SIR Managemer	X					$	$			$ 8,890	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										8,890	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.)

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 829,300	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.)		$ 860,476	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,176	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 885,000	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.)**		$ 53,901	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** $ 209,663 **For** 10-'12 **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.		$ 970,076	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	683,760	8
	2010	665,529	9
	2011	744,862	10
	2012	783,781	11
	2013	849,760	12

2014 Accrual = $849,760 x 1.04 = $885,000 (Rounded)

Beginning Accrual Adjusted

Allocated from SIR Management = $10,716

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Rehabilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31-401-046-0000	Long Term Care Property	$ 849,759.62	$ 849,759.62
2.	See Attached	Home Office	$ 116,016.54	$ 10,129.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 965,776.16	$ 859,889.56

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Rehabilitation Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2009	$ 875,000	1
2					2
3	TOTALS			$ 875,000	3

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300			1976	$ 12,900,000	$ 547,847	39	$ 330,769	$ (217,078)	$ 1,605,493	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	252,676		20	14,792	14,792	97,396	9
10	Various			2009	547,020		20	27,777	27,777	160,394	10
11	Various			2010	392,518		20	19,929	19,929	97,204	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
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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)		8,216,030			410,802	410,802	1,700,968	67
68	Related Party Allocations (Pages 12H & 12I)		202,495	5,466		7,757	2,291	98,999	68
69	Financial Statement Depreciation			156,559			(156,559)		69
70	TOTAL (lines 4 thru 69)		$ 22,510,739	$ 709,872		$ 811,825	$ 101,953	$ 3,760,454	70

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12A, Carried Forward		$ 22,510,739	$ 709,872		$ 811,825	$ 101,953	$ 3,760,454	1
2	Fire System Tank	2011	2,985		20	149	149	597	2
3	Security Camera System	2011	7,967		20	1,593	1,593	6,108	3
4	Hvac- Coil Replacement	2011	12,168		20	608	608	2,231	4
5	Fire System- Sensor Modules	2011	3,064		20	153	153	562	5
6	Security Camera System	2011	8,612		20	1,722	1,722	6,459	6
7	Elevator Motor Work	2011	9,175		20	459	459	1,644	7
8	Elevator Door Operator	2011	8,547		20	427	427	1,496	8
9	Overbed Lights (24)	2011	2,330		20	233	233	796	9
10	Magnetic Door Closers	2011	7,474		20	374	374	1,246	10
11	Fire Pump Work	2011	3,225		20	161	161	538	11
12	Fire Alarm System Work	2011			20				12
13	Fire Alarm System Work	2011	4,641		20	232	232	754	13
14	Fire Doors	2011	3,300		20	165	165	523	14
15	Closet Soffit	2011	6,497		20	325	325	1,218	15
16	Repair Air Handler	2011	3,941		20	197	197	755	16
17	Replace Belts & Exhaust Fans	2011	15,623		20	781	781	2,929	17
18	Elevator Work	2011	3,778		20	189	189	724	18
19	Replace Valves	2011	3,190		20	160	160	598	19
20	Repair Coel	2011	2,795		20	140	140	559	20
21	Replace Control & Valve	2011	8,491		20	425	425	1,698	21
22	Prep / Paint 16 Rooms	2011	6,784		20	339	339	1,046	22
23	Water Purification System	2011	3,831		20	192	192	591	23
24	Carpet & Flooring	2011	3,717		20	186	186	743	24
25	Sprinkler Heads	2011	5,679		20	284	284	1,136	25
26	Elevator Flooring	2011	7,432		20	372	372	1,486	26
27	Elevator Panels	2011	9,000		20	450	450	1,800	27
28	Resident Flooring - 1St Floor	2011	25,357		20	1,268	1,268	5,071	28
29	Asbestos Handling	2011	441,394		20	22,070	22,070	88,279	29
30	Check Valves, Sprayer, Faucet	2011	5,731		20	287	287	1,146	30
31	Sprinkler Heads	2011	9,299		20	465	465	1,860	31
32	2,3,4, Flr Bathrooms - Tiles, Walls, Flr	2011	190,991		20	9,550	9,550	38,198	32
33	Protective Bumpers	2012	4,200		20	420	420	1,260	33
34	TOTAL (lines 1 thru 33)		$ 23,341,956	$ 709,872		$ 856,199	$ 146,327	$ 3,934,505	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12B, Carried Forward		$ 23,341,956	$ 709,872		$ 856,199	$ 146,327	$ 3,934,505	1
2	Boiler Work	2012	10,499		20	525	525	1,575	2
3	Boiler Work	2012	9,418		20	471	471	1,334	3
4	Boiler Work	2012	4,109		20	205	205	548	4
5	Fire Panel Work	2012	3,982		20	199	199	514	5
6	Ceiling Fan Insulation	2012	11,185		20	559	559	1,398	6
7	Privacy Curtains	2012	3,034		20	152	152	329	7
8	Tuckpointing	2012	12,000		20	600	600	1,300	8
9	Compressor	2012	5,348		20	267	267	557	9
10	Tuckpointing & Caulking	2012	49,045		20	2,452	2,452	5,109	10
11	Handrails	2012	5,325		20	266	266	710	11
12	Installed Piping In 2 Showers	2012	3,981		20	199	199	531	12
13	Monitor Modules Floors 1, 2, 3, 4	2012	2,818		20	141	141	376	13
14	Crash Rails - 3Rd And 4Th Floor Dining Rooms	2013	4,628		20	231	231	444	14
15	Water Main Upgrade	2013	14,950		20	748	748	1,246	15
16	Air Conditioner	2013	5,158		20	258	258	408	16
17	Furnish & Install New Tank Unit In Elevator	2013	9,870		20	494	494	699	17
18	Install Windows Throughout Entire Building	2013	224,726		20	11,236	11,236	18,727	18
19	Repipe Water Line	2013	3,200		20	160	160	307	19
20	Spray Fireproofing	2013	6,380		20	319	319	558	20
21	Wall Unit Air Conditioners	2013	7,993		20	400	400	666	21
22	Sprinkler System Work	2014	7,681		20	352	352	352	22
23	Air Conditioner Cut Outs	2014	3,600		20	165	165	165	23
24	Custom Cabinets - 3 Rms And Patient	2014	16,200		20	810	810	810	24
25	Fire Sprinkler Line Valve	2014	9,350		20	312	312	312	25
26	Front Door Access Control	2014	4,859		20	20	20	20	26
27	Masonry Infills	2014	3,460		20	173	173	173	27
28	10 Air Conditioners	2014	6,199		20	310	310	310	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 23,790,954	$ 709,872		$ 878,224	$ 168,352	$ 3,973,982	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12C, Carried Forward		$ 23,790,954	$ 709,872		$ 878,224	$ 168,352	$ 3,973,982	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 23,790,954	$ 709,872		$ 878,224	$ 168,352	$ 3,973,982	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12D, Carried Forward		$ 23,790,954	$ 709,872		$ 878,224	$ 168,352	$ 3,973,982	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 23,790,954	$ 709,872		$ 878,224	$ 168,352	$ 3,973,982	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12E, Carried Forward		$	$		$	$	$	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	921	921	5,523	9
10	Flooring	2009	44,832		20	2,242	2,242	13,450	10
11	Hand Rails/ Guards	2009	29,804		20	1,490	1,490	8,941	11
12	Drapes, Cubicles, Coverlets	2010	166,306		20	8,315	8,315	41,577	12
13	Handrails	2010	59,608		20	2,980	2,980	14,902	13
14	Dialysis Room Piping	2010	19,324		20	966	966	4,831	14
15	Painting- 2nd Floor	2010	35,410		20	1,771	1,771	8,853	15
16	Painting- 4th Floor	2009	52,610		20	2,631	2,631	15,783	16
17	Pegasus- Nursing Stations	2009	165,000		20	8,250	8,250	49,500	17
18	Built In Furniture	2009	299,000		20	14,950	14,950	89,700	18
19	Flooring	2009	208,860		20	10,443	10,443	62,658	19
20	Flooring	2010	116,064		20	5,803	5,803	29,016	20
21	Window Treatments	2010	7,202		20	360	360	1,801	21
22	Corner Gaurds	2010	5,103		20	255	255	1,276	22
23	Flooring	2010	15,532		20	777	777	3,883	23
24	Telephone System	2010	42,428		20	2,121	2,121	10,607	24
25	Overbed Lights	2010	5,573		20	279	279	1,393	25
26	Overbed Lights	2010	9,240		20	462	462	2,310	26
27	Interior Signage	2010	5,424		20	271	271	1,356	27
28	Interior Signage	2010	4,305		20	215	215	1,076	28
29	Lighting	2010	26,692		20	1,335	1,335	6,673	29
30	Ist Floor Resident Room Work	2011	4,500		20	225	225	900	30
31	PT Recovery Room	2011	4,000		20	200	200	800	31
32	Dialysis Water Purification	2011	6,385		20	319	319	1,277	32
33	Custom Cabinets	2011	4,000		20	200	200	800	33
34	TOTAL (lines 1 thru 33)		$ 1,355,612	$		$ 67,781	$ 67,781	$ 378,885	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12F, Carried Forward		$ 1,355,612	$		$ 67,781	$ 67,781	$ 378,885	1
2	Grocery Cabinets	2011	7,900		20	395	395	1,580	2
3	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	1,849	3
4	Sump Pump	2011	7,342		20	367	367	1,468	4
5	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	2,268	5
6	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	5,740	6
7	Cabinetry	2011	8,600		20	430	430	1,720	7
8	Window Treatment	2011	11,587		20	579	579	2,317	8
9	Window Treatment	2011	19,302		20	965	965	3,860	9
10	Window Treatments	2011	3,003		20	150	150	601	10
11	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	1,410	11
12	Install Corner Guards	2011	3,840		20	192	192	768	12
13	Kitchen Dishwasher Install	2011	5,306		20	265	265	1,061	13
14	Family Room Wall Prep & Paint	2011	2,700		20	135	135	540	14
15	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	1,300	15
16	Dialysis, Therapy, & Dining Rooms & 1st Flr & Basement Remode	2011	5,662,788		20	283,139	283,139	1,132,558	16
17	Architect Fees-Dialysis, Therapy&Dining Rooms&1st Flr&Baseme	2011	479,093		20	23,955	23,955	95,819	17
18	Fees Dialysis, Therapy & Dining Rooms & 1st Flr & Basement Ren	2011	299,630		20	14,982	14,982	59,926	18
19	Contracter Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & Ba	2011	36,491		20	1,825	1,825	7,298	19
20	Administrative Offices	2009	250,000		20	12,500	12,500		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)		$ 8,216,030	$		$ 410,802	$ 410,802	$ 1,700,968	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - S.I.R. Management	2009	27,873		39	715	715	3,603	3
4	Allocated - S.I.R. Properties - S.I.R. Management	1993	50,468	1,602	35	1,442	(160)	31,001	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - S.I.R. Management	1993	12,795	356	20		(356)	12,795	9
10	Allocated - S.I.R. Management	1994	40		20			40	10
11	Allocated - S.I.R. Management	1995	292		20	15	15	284	11
12	Allocated - S.I.R. Management	1997	19,661	440	20	958	518	17,414	12
13	Allocated - S.I.R. Management	1999	1,546		20	77	77	1,178	13
14	Allocated - S.I.R. Management	2000	1,825		20	91	91	1,327	14
15	Allocated - S.I.R. Management	2007	5,864	400	20	293	(107)	2,109	15
16	Allocated - S.I.R. Management	2008	16,162	1,544	20	1,019	(525)	6,972	16
17	Allocated - S.I.R. Management	2009	40,160	367	20	2,008	1,641	10,531	17
18	Allocated - S.I.R. Management	2011	994	99	20	99		339	18
19	Allocated - S.I.R. Management	2012	3,179	159	20	159		384	19
20	Allocated - S.I.R. Management	2014	446		20	13	13	13	20
21									21
22	Allocated - S.I.R. Properties - S.I.R. Management	2012	3,091	304	20	15	(289)	40	22
23	Allocated - S.I.R. Properties - S.I.R. Management	2010	3,045		20	152	152	660	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2009	3,030	135	20	152	17	879	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2007	884	44	20	44		353	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2002	200		20	10	10	125	26
27	Allocated - S.I.R. Properties - S.I.R. Management	1999	6,395		20	320	320	4,956	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1998	3,056		20	153	153	2,521	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1997	190		20	10	10	176	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1994	481	12	20	12		481	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1993	818	4	20		(4)	818	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 202,495	$ 5,466		$ 7,757	$ 2,291	$ 98,999	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Totals from Page 12H, Carried Forward		$ 202,495	$ 5,466		$ 7,757	$ 2,291	$ 98,999	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 202,495	$ 5,466		$ 7,757	$ 2,291	$ 98,999	34

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,521,102	$ 140,933	$ 152,088	$ 11,155	10	$ 659,268	71
72	Current Year Purchases	58,596	206	4,189	3,983	10	4,189	72
73	Fully Depreciated Assets	106,159				10	106,159	73
74								74
75	TOTALS	$ 1,685,857	$ 141,139	$ 156,277	$ 15,138		$ 769,617	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 SIR Management	2014	$ 3,919	$ 355	$ 419	$ 64	5	$ 2,258	76
77										77
78										78
79										79
80	TOTALS			$ 3,919	$ 355	$ 419	$ 64		$ 2,258	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 26,355,730	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 851,366	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,034,920	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 183,554	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,745,857	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	Resident Communication Syste	$ 88,353	92
93			93
94			94
95		$ 88,353	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.

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 7,262 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	Allocated from SIR Management		$	$ 7,599	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,599	21

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
   - [X] 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)

		1	2	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.

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	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	$		$ 483,175	$		$ 483,175	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			161,531			161,531	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			733,765			733,765	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				408,002		408,002	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						295,868		295,868	13
14	TOTAL			$		$ 1,378,471	$ 703,870		$ 2,082,341	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.

STATE OF ILLINOIS

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,533	$ 323,393	1
2	Cash-Patient Deposits	97,765	97,765	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,685,920	3,685,920	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,984	284,777	6
7	Other Prepaid Expenses	4,414	4,414	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		662,178	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,143,616	$ 5,258,447	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		19,842,535	14
15	Leasehold Improvements, at Historical Cost	2,234,263	3,752,291	15
16	Equipment, at Historical Cost	573,214	1,664,170	16
17	Accumulated Depreciation (book methods)	(664,737)	(3,778,390)	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):	88,353	8,473,061	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,231,093	$ 31,453,667	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,374,709	$ 36,712,114	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 659,969	$ 659,970	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	97,765	97,765	28
29	Short-Term Notes Payable	2,950,000	6,250,000	29
30	Accrued Salaries Payable	310,016	310,016	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,459	38,459	31
32	Accrued Real Estate Taxes(Sch.IX-B)		885,000	32
33	Accrued Interest Payable		75,695	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	193,890	193,890	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,250,099	$ 8,510,795	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		25,587,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 25,587,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,250,099	$ 34,097,795	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,124,610	$ 2,614,319	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,374,709	$ 36,712,114	48

*(See instructions.)

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,168,608	1	
2	Restatements (describe):		2	
3	**Rounding**	(2)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,168,606	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	978,356	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,022,352)	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)**	$ (43,996)	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)**	$ 2,124,610	24	*

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,652,346	1
2	Discounts and Allowances for all Levels	(5,131,061)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,521,285	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,320,291	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,320,291	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	358,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,355	19
20	Radiology and X-Ray	2,576	20
21	Other Medical Services	60,040	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 457,748	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,733	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,733	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	361,307	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 361,307	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,662,364	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,747,851	31
32	Health Care	5,561,886	32
33	General Administration	4,179,220	33
	B. Capital Expense		
34	Ownership	3,322,641	34
	C. Ancillary Expense		
35	Special Cost Centers	2,252,203	35
36	Provider Participation Fee	620,207	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,684,008	40
41	**Income before Income Taxes (line 30 minus line 40)****	978,356	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 978,356	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,757,447	44
45	Private Pay - Net Inpatient Revenue	1,302,320	45
46	Medicare - Net Inpatient Revenue	1,283,513	46
47	Other-(specify) Hospice	302,264	47
48	Other-(specify) HMO / Insurance	875,741	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,521,285	49

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

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

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

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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,988	2,153	$ 102,320	$ 47.52	1
2	Assistant Director of Nursing	1,893	2,068	76,096	36.80	2
3	Registered Nurses	36,771	39,456	1,104,395	27.99	3
4	Licensed Practical Nurses	43,601	46,067	1,074,568	23.33	4
5	CNAs & Orderlies	156,832	166,714	1,883,116	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,021	7,811	137,284	17.58	8
9	Activity Director					9
10	Activity Assistants	21,950	23,519	248,433	10.56	10
11	Social Service Workers	10,309	10,870	165,889	15.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,448	48,157	538,746	11.19	15
16	Dishwashers					16
17	Maintenance Workers	7,048	7,830	151,963	19.41	17
18	Housekeepers	33,416	36,154	347,720	9.62	18
19	Laundry	16,009	17,637	165,505	9.38	19
20	Administrator	4,085	4,389	212,336	48.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,408	16,551	214,916	12.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,508	9,098	238,666	26.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	8,641	9,561	225,420	23.58	33
34	TOTAL (lines 1 - 33)	417,928	448,035	$ 6,887,373 *	$ 15.37	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 22,560	01-03	35
36	Medical Director	Monthly	50,400	09-03	36
37	Medical Records Consultant	Monthly	4,992	10-03	37
38	Nurse Consultant	Monthly	86,400	10-03	38
39	Pharmacist Consultant	Monthly	19,730	10-03	39
40	Physical Therapy Consultant	129	6,456	10a-03	40
41	Occupational Therapy Consultant	18	889	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	894	10a-03	43
44	Activity Consultant	Monthly	5,139	11-03	44
45	Social Service Consultant	Monthly	6,298	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)	165	$ 268,558		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Barrish 1/1 - 6/30	Administrator	1.56	$ 60,270
Burton Barrish 1/1 - 8/31	Administrator	0	49,373
Lea Radunsky	Administrator	0	24,138
Lorrie Woebbeking 6/1 - 12/31	Administrator	0	78,554
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 212,335

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 871,838
SIR Management - Director of Administrative Services	86,400
SIR Management - Ancillary Admin. Charges	72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,030,238
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 17,345
Plante Moran	401K Consulting	6,125
McGladrey	Accounting	2,900
Personnel Planners, Inc.	Unemployment Tax Consult	3,725
SIR Management	Dir. Of Regulatory Services	43,200
SIR Management	Dir. Of Financial Services	36,000
SIR Management	Bookkeeping	147,600
SIR Management	Computer Support	25,200
H.K. Payroll	WOTC Consulting	3,498
Achieve Accreditation	Accreditation	8,533
E-Health Data	Data Processing	3,300
See Supplemental Schedule		14,928
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 312,353

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,830
Unemployment Compensation Insurance	147,302
FICA Taxes	518,766
Employee Health Insurance	592,091
Employee Meals	35,314
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching Contributions	8,331
Other Employee Benefits	14,417
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,438,050

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,703
Advertising: Employee Recruitment	41,251
Health Care Worker Background Check	
(Indicate # of checks performed 667)	6,672
Patient Background Checks	
Dues & Subcriptions	21,569
Licenses & Fees	13,653
Allocated from SIR Management	4,119
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 89,967

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,878
Allocated from SIR Management	1,155
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,033

**See instructions.

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Regency Rehabilitation Ctr # 0049841 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: $24,453**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,472** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **620,207**
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. $ **35,314** 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.