FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0049841

Facility Name: Regency Rehabilitation Center, Llc

Address: 6631 Milwaukee Avenue (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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	49,937	7,615	19,378	76,930	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,937	7,615	19,378	76,930	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.26%

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 [X] NO [ ]

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 7,652

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	519,832	90,420	59,200	669,452		669,452	(25,911)	643,541			1
2	Food Purchase		598,077		598,077	(39,584)	558,493	(589)	557,904			2
3	Housekeeping	350,208	85,487		435,695		435,695		435,695			3
4	Laundry	167,413	58,615		226,028		226,028		226,028			4
5	Heat and Other Utilities			301,851	301,851		301,851	(8,034)	293,817			5
6	Maintenance	151,929	49,468	284,619	486,016		486,016	(3,753)	482,263			6
7	Other (specify):*							10,599	10,599			7
8	**TOTAL General Services**	1,189,382	882,067	645,670	2,717,119	(39,584)	2,677,535	(27,689)	2,649,846			8
	B. Health Care and Programs											
9	Medical Director			45,500	45,500		45,500		45,500			9
10	Nursing and Medical Records	4,471,747	269,687	123,206	4,864,640		4,864,640	(40,609)	4,824,031			10
10a	Therapy	149,603		42,557	192,160		192,160	(13,737)	178,423			10a
11	Activities	248,636	15,376	6,952	270,964		270,964		270,964			11
12	Social Services	167,683		3,752	171,435		171,435		171,435			12
13	CNA Training											13
14	Program Transportation			883	883		883		883			14
15	Other (specify):*							8,486	8,486			15
16	**TOTAL Health Care and Programs**	5,037,669	285,063	222,850	5,545,582		5,545,582	(45,860)	5,499,722			16
	C. General Administration											
17	Administrative	231,184		558,503	789,687		789,687	(408,340)	381,347			17
18	Directors Fees											18
19	Professional Services			453,246	453,246		453,246	(308,397)	144,849			19
20	Dues, Fees, Subscriptions & Promotions			138,477	138,477		138,477	(88,435)	50,042			20
21	Clerical & General Office Expenses	262,407	32,472	774,215	1,069,094		1,069,094	(548,225)	520,869			21
22	Employee Benefits & Payroll Taxes			1,332,546	1,332,546	39,584	1,372,130		1,372,130			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,521	3,521		3,521	1,625	5,146			24
25	Other Admin. Staff Transportation			6,550	6,550		6,550	9,617	16,167			25
26	Insurance-Prop.Liab.Malpractice			236,060	236,060		236,060	27,158	263,218			26
27	Other (specify):*							54,326	54,326			27
28	**TOTAL General Administration**	493,591	32,472	3,503,118	4,029,181	39,584	4,068,765	(1,260,670)	2,808,095			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,720,642	1,199,602	4,371,638	12,291,882		12,291,882	(1,334,219)	10,957,663			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 Center, Llc #0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			158,359	158,359		158,359	915,152	1,073,511			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,854	110,854		110,854	871,266	982,120			32
33	Real Estate Taxes							884,879	884,879			33
34	Rent-Facility & Grounds			3,060,000	3,060,000		3,060,000	(3,060,000)				34
35	Rent-Equipment & Vehicles			5,284	5,284		5,284	9,143	14,427			35
36	Other (specify):*							232,743	232,743			36
37	TOTAL Ownership			3,334,497	3,334,497		3,334,497	(146,817)	3,187,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		697,610	1,219,678	1,917,288		1,917,288	(4,967)	1,912,321			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			596,850	596,850		596,850	(2,070)	594,780			42
43	Other (specify):*	91,515			91,515		91,515	(91,515)				43
44	TOTAL Special Cost Centers	91,515	697,610	1,816,528	2,605,653		2,605,653	(98,552)	2,507,101			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,812,157	1,897,212	9,522,663	18,232,032		18,232,032	(1,579,588)	16,652,444			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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(14,764)	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	211,950	30		9
10	Interest and Other Investment Income	(12,113)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(589)	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	(1,033)	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	(686,566)	21		24
25	Fund Raising, Advertising and Promotional	(49,121)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(186,411)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (738,647)		$	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)	(840,941)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (840,941)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,579,588)		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

Regency Rehabilitation Center, Llc

ID# 0049841

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (91,515)	43	1
2	Legal Fees - Non Allowable	(28,959)	19	2
3	Bank Fees	(6,640)	21	3
4	Theft & Damage	(3,327)	21	4
5	LLC Annual Report Fee	(250)	20	5
6	Capitalized R&M	(2,971)	06	6
7	CMS & IDPH Penalties	(28,597)	20	7
8	PAC Dues	(11,675)	20	8
9	Bldg Co. - Licenses	(45)	20	9
10	Bldg Co. - Additional R&M	2,123	06	10
11	PY Nursing Supply	(3,465)	10	11
12	PY Repairs & Maintenance	(1,657)	06	12
13	PY Provider Assessment	(2,070)	42	13
14	PY Wound Care	(2,881)	10	14
15	PY Enternal Supply	(4,483)	10	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(186,411)		49

Regency Rehabilitation Center, Llc

ID# 0049841

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(25,911)								(25,911)	1
2	Food Purchase	(589)											(589)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,764)	3,493		3,237								(8,034)	5
6	Maintenance	(2,505)	11,396	(36,414)	23,769								(3,753)	6
7	Other (specify):*				10,599								10,599	7
8	**TOTAL General Services**	(17,858)	14,889	(36,414)	11,694								(27,689)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(10,829)		(40,663)	11,127	(244)							(40,609)	10
10a	Therapy				(13,737)								(13,737)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,826	3,660								8,486	15
16	**TOTAL Health Care and Programs**	(10,829)		(35,837)	1,050	(244)							(45,860)	16
	C. General Administration													
17	Administrative			(522,330)	113,990								(408,340)	17
18	Directors Fees													18
19	Professional Services	(28,959)		(301,107)	21,669								(308,397)	19
20	Fees, Subscriptions & Promotions	(90,721)	45	2,241									(88,435)	20
21	Clerical & General Office Expenses	(696,533)		148,164	144								(548,225)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,625									1,625	24
25	Other Admin. Staff Transportation			9,617									9,617	25
26	Insurance-Prop.Liab.Malpractice		23,952	2,893	313								27,158	26
27	Other (specify):*			29,739	24,587								54,326	27
28	**TOTAL General Administration**	(816,213)	23,997	(629,158)	160,703								(1,260,670)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(844,899)	38,886	(701,409)	173,447	(244)							(1,334,219)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	211,950	693,185		10,017								915,152	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,113)	893,848	(19,376)	8,907								871,266	32
33	Real Estate Taxes		873,316		11,563								884,879	33
34	Rent-Facility & Grounds		(3,060,000)										(3,060,000)	34
35	Rent-Equipment & Vehicles			9,143									9,143	35
36	Other (specify):*		232,743										232,743	36
37	**TOTAL Ownership**	199,837	(366,908)	(10,233)	30,487								(146,817)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(4,882)	(86)						(4,967)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(2,070)											(2,070)	42
43	Other (specify):*	(91,515)											(91,515)	43
44	**TOTAL Special Cost Centers**	(93,585)				(4,882)	(86)						(98,552)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(738,647)	(328,022)	(711,642)	203,934	(5,126)	(86)						(1,579,588)	45

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	693,185	693,185	2
3	V	20	Licenses		6631 N. Milwaukee, LLC	100.00%	45	45	3
4	V	32	Interest Income	204	6631 N. Milwaukee, LLC	100.00%		(204)	4
5	V	32	Interest Expense		6631 N. Milwaukee, LLC	100.00%	894,052	894,052	5
6	V	36	Mortgage Insurance		6631 N. Milwaukee, LLC	100.00%	232,743	232,743	6
7	V	26	Property Insurance		6631 N. Milwaukee, LLC	100.00%	23,952	23,952	7
8	V	33	Real Estate Taxes		6631 N. Milwaukee, LLC	100.00%	873,316	873,316	8
9	V	06	Repairs		6631 N. Milwaukee, LLC	100.00%	11,396	11,396	9
10	V	05	Utility		6631 N. Milwaukee, LLC	100.00%	3,493	3,493	10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,060,204			$ 2,732,182	$ * (328,022)	14

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	$ 43,200	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,786	$ (36,414)	15
16	V								16
17	V	10	NURSING	93,600	S.I.R. MANAGEMENT, INC.	100.00%	52,937	(40,663)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,826	4,826	18
19	V	19	PROFESSIONAL FEES	307,200	S.I.R. MANAGEMENT, INC.	100.00%	5,477	(301,723)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,241	2,241	20
21	V	21	CLERICAL & GENERAL	43,200	S.I.R. MANAGEMENT, INC.	100.00%	171,661	128,461	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,625	1,625	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,617	9,617	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,893	2,893	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,089	9,089	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(19,376)	(19,376)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,772	7,772	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,371	1,371	28
29	V								29
30	V	17	ADMINISTRATIVE	558,503	S.I.R. MANAGEMENT, INC.	100.00%	36,173	(522,330)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	616	616	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	19,703	19,703	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,650	20,650	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,045,703			$ 334,061	$ * (711,642)	39

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 10,089	$ (25,911)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,407	1,407	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	11,127	11,127	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,540	1,540	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	113,990	113,990	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	21,562	21,562	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	24,587	24,587	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,800	S.I.R. MANAGEMENT, INC.	100.00%	15,063	(13,737)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,120	2,120	25
26	V								26
27	V	6	MAINTENANCE SALARIES	39,472	S.I.R. MANAGEMENT, INC.	100.00%	61,423	21,951	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	9,192	9,192	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	3,237	3,237	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,818	1,818	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	107	107	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	144	144	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	313	313	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	10,017	10,017	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	8,907	8,907	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	11,563	11,563	37
38	V								38
39	Total			$ 104,272			$ 308,206	$ * 203,934	39

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 18,488	MAC Rx, LLC	100.00%	$ 18,243	$ (244)	15
16	V	39	Ancillary	369,693	MAC Rx, LLC	100.00%	364,811	(4,882)	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			$ 388,181			$ 383,055	$ * (5,126)	39

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 10,313	Long Term Care Laboratory, LLC	100.00%	$ 10,227	$ (86)	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			$ 10,313			$ 10,227	$ * (86)	39

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	34.72%	ALBANY CARE INC	EVANSTON	6631 MILWAUKEE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LTD PARTNERSHIP	12.15%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	12.15%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	JOSHUA DAVID BEHR	1.56%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	LINDSEY ERIN BEHR	1.56%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	LORI BARRISH	1.56%	ELMWOOD CARE, INC.	ELMWOOD PARK	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	MICHAEL GIANNINI TRUST	10.42%	GREENWOOD CARE, INC.	EVANSTON				7
8	RALPH GESULADO	12.15%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	RALPH GESULADO CHILDREN'S TRUST	12.15%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				9
10	THOMAS WINTER	1.56%	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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3.73	9.33%	Alloc. Salary	$ 18,238	17-07	1
2	Tom Winter	Owner	Administrative	1.56%	See Attached	6.40	10.67%	Alloc. Salary	21,333	17-07	2
3	Bryan Barrish	Relative	Administrative	0%	See Attached	4.27	9.49%	Alloc. Salary	21,333	17-07	3
4	Sarah Barrish	Relative	Administrative	0%	See Attached	4.80	10.67%	Alloc. Salary	11,237	17-07	4
5	Kirsten Schloss	Relative	Maintenance	0%	See Attached	5.33	10.66%	Alloc. Salary	10,274	06-07	5
6	Nenita Guzman	Relative	Dietary	0%	See Attached	5.33	10.66%	Alloc. Salary	10,089	01-07	6
7											7
8											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	$ 92,504		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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	76,930	$ 6,786	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	76,930	52,937	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		76,930	4,826	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		76,930	5,477	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		76,930	2,241	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	76,930	171,661	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		76,930	1,625	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		76,930	9,617	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		76,930	2,893	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		76,930	9,089	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		76,930	(19,376)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		76,930	7,772	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		76,930	1,371	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	76,930	36,173	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		76,930	616	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	76,930	19,703	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		76,930	20,650	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 334,061	25

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	76,930	$ 10,089	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		76,930	1,407	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	76,930	11,127	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		76,930	1,540	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	76,930	113,990	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		76,930	21,562	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		76,930	24,587	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	28,800	15,063	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		28,800	2,120	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	39,472	61,423	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		39,472	9,192	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		1,374	3,237	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		1,374	1,818	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		1,374	107	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		1,374	144	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		1,374	313	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		1,374	10,017	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		1,374	8,907	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		1,374	11,563	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 308,206	25

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 18,243	1
2	39	Ancillary	Direct Allocation						364,811	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					$	$		$ 383,055	25

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 10,227	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					$	$		$ 10,227	25

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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				$	$ 25,206,650			$ 894,052	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				2,420,000			110,854	6
7	Allocated from SIR Managemen	X									8,907	7
8												8
9	TOTAL Facility Related						$	$ 27,626,650			$ 1,013,813	9
	B. Non-Facility Related*											
10	Interest Income		X								(12,113)	10
11	Allocated from SIR Managemen	X									(19,376)	11
12	Building Co - Interest Inc		X								(204)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31,693)	14
15	TOTALS (line 9+line14)						$	$ 27,626,650			$ 982,120	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 232,743 **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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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 Center, Llc **#** 0049841 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 885,256	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.)		$ 864,035	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21,221)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 906,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 884,879	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	665,529	8
	2011	744,862	9
	2012	783,781	10
	2013	849,760	11
	2014	852,472	12

2014 Accrual = $852,472 x 1.05 = $906,100 (Rounded)
Allocated from SIR Management = $11,563
Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT 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 2014 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 2014.

	(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	$ 862,948.02	$ 852,471.88
2.	See Attached	Home Office	$ 118,674.75	$ 9,916.19
3.	See Attached	SIR Training	$ 862,948.02	$ 1,117.74
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,844,570.79	$ 863,505.81

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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Center, Llc 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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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).

SIR Training Center - 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	$ 950,000	1
2					2
3	TOTALS			$ 950,000	3

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 584,216	39	$ 330,769	$ (253,447)	$ 1,936,262	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	252,676		20	12,327	12,327	109,723	9
10	Various			2009	547,020		20	50,363	50,363	121,145	10
11	Various			2010	392,518		20	20,023	20,023	111,687	11
12	Various			2011	827,017		20	43,954	43,954	209,371	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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		8,519,733			425,987	425,987	2,126,955	67
68	Related Party Allocations (Pages 12H & 12I)		220,457	6,221		8,094	1,873	106,284	68
69	Financial Statement Depreciation			158,359			(158,359)		69
70	TOTAL (lines 4 thru 69)		$ 23,659,421	$ 748,796		$ 891,518	$ 142,722	$ 4,721,427	70

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 23,659,421	$ 748,796		$ 891,518	$ 142,722	$ 4,721,427	1
2	Protective Bumpers	2012	4,200		20	420	420	1,680	2
3	Boiler Work	2012	10,499		20	525	525	2,100	3
4	Boiler Work	2012	9,418		20	471	471	1,805	4
5	Boiler Work	2012	4,109		20	205	205	753	5
6	Fire Panel Work	2012	3,982		20	199	199	713	6
7	Ceiling Fan Insulation	2012	11,185		20	559	559	1,957	7
8	Privacy Curtains	2012	3,034		20	152	152	480	8
9	Tuckpointing	2012	12,000		20	600	600	1,900	9
10	Compressor	2012	5,348		20	267	267	824	10
11	Tuckpointing & Caulking	2012	49,045		20	2,452	2,452	7,561	11
12	Handrails	2012	5,325		20	266	266	976	12
13	Installed Piping In 2 Showers	2012	3,981		20	199	199	730	13
14	Monitor Modules Floors 1, 2, 3, 4	2012	2,818		20	141	141	517	14
15	Crash Rails - 3Rd And 4Th Floor Dining Rooms	2013	4,628		20	231	231	675	15
16	Water Main Upgrade	2013	14,950		20	748	748	1,993	16
17	Air Conditioner	2013	5,158		20	258	258	666	17
18	Furnish & Install New Tank Unit In Elevator	2013	9,870		20	494	494	1,193	18
19	Install Windows Throughout Entire Building	2013	224,726		20	11,236	11,236	29,963	19
20	Repipe Water Line	2013	3,200		20	160	160	467	20
21	Spray Fireproofing	2013	6,380		20	319	319	877	21
22	Wall Unit Air Conditioners	2013	7,993		20	400	400	1,066	22
23	Sprinkler System Work	2014	7,681		20	384	384	736	23
24	Air Conditioner Cut Outs	2014	3,600		20	180	180	345	24
25	Custom Cabinets - 3 Rms And Patient	2014	16,200		20	810	810	1,620	25
26	Fire Sprinkler Line Valve	2014	9,350		20	468	468	779	26
27	Front Door Access Control	2014	4,859		20	243	243	263	27
28	Masonry Infills	2014	3,460		20	173	173	303	28
29	10 Air Conditioners	2014	6,199		20	310	310	517	29
30	Video Camera & Monitors	2015	2,792		20	23	23	23	30
31	Freight Elevator - Replaced Defective Board	2015	2,971		20	149	149	149	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	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
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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)		$ 24,118,381	$ 748,796		$ 914,560	$ 165,764	$ 4,785,060	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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	6,444	9
10	Flooring	2009	44,832		20	2,242	2,242	15,691	10
11	Hand Rails/ Guards	2009	29,804		20	1,490	1,490	10,431	11
12	Drapes, Cubicles, Coverlets	2010	166,306		20	8,315	8,315	49,892	12
13	Handrails	2010	59,608		20	2,980	2,980	17,882	13
14	Dialysis Room Piping	2010	19,324		20	966	966	5,797	14
15	Painting- 2nd Floor	2010	35,410		20	1,771	1,771	10,623	15
16	Painting- 4th Floor	2009	52,610		20	2,631	2,631	18,414	16
17	Pegasus- Nursing Stations	2009	165,000		20	8,250	8,250	57,750	17
18	Built In Furniture	2009	299,000		20	14,950	14,950	104,650	18
19	Flooring	2009	208,860		20	10,443	10,443	73,101	19
20	Flooring	2010	116,064		20	5,803	5,803	34,819	20
21	Window Treatments	2010	7,202		20	360	360	2,161	21
22	Corner Gaurds	2010	5,103		20	255	255	1,531	22
23	Flooring	2010	15,532		20	777	777	4,660	23
24	Telephone System	2010	42,428		20	2,121	2,121	12,728	24
25	Overbed Lights	2010	5,573		20	279	279	1,672	25
26	Overbed Lights	2010	9,240		20	462	462	2,772	26
27	Interior Signage	2010	5,424		20	271	271	1,627	27
28	Interior Signage	2010	4,305		20	215	215	1,292	28
29	Lighting	2010	26,692		20	1,335	1,335	8,008	29
30	Ist Floor Resident Room Work	2011	4,500		20	225	225	1,125	30
31	PT Recovery Room	2011	4,000		20	200	200	1,000	31
32	Dialysis Water Purification	2011	6,385		20	319	319	1,596	32
33	Custom Cabinets	2011	4,000		20	200	200	1,000	33
34	TOTAL (lines 1 thru 33)		$ 1,355,612	$		$ 67,781	$ 67,781	$ 446,665	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 446,665	1
2	Grocery Cabinets	2011	7,900		20	395	395	1,975	2
3	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	2,311	3
4	Sump Pump	2011	7,342		20	367	367	1,836	4
5	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	2,835	5
6	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	7,175	6
7	Cabinetry	2011	8,600		20	430	430	2,150	7
8	Window Treatment	2011	11,587		20	579	579	2,897	8
9	Window Treatment	2011	19,302		20	965	965	4,826	9
10	Window Treatments	2011	3,003		20	150	150	751	10
11	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	1,763	11
12	Install Corner Guards	2011	3,840		20	192	192	960	12
13	Kitchen Dishwasher Install	2011	5,306		20	265	265	1,327	13
14	Family Room Wall Prep & Paint	2011	2,700		20	135	135	675	14
15	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	1,625	15
16	Dialysis, Therapy, & Dining Rooms & 1st Flr & Basement Remod	2011	5,662,788		20	283,139	283,139	1,415,697	16
17	Architect Fees-Dialysis, Therapy&Dining Rooms&1st Flr&Basem	2011	479,093		20	23,955	23,955	119,773	17
18	Fees Dialysis, Therapy & Dining Rooms & 1st Flr & Basement Re	2011	299,630		20	14,982	14,982	74,908	18
19	Contracter Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & B	2011	36,491		20	1,825	1,825	9,123	19
20	Administrative Offices	2009	250,000		20	12,500	12,500	12,500	20
21	Walk-in Freezer Work	2015	8,484		20	424	424	424	21
22	Door to Walk-in Freezer	2015	4,767		20	238	238	238	22
23	Wireless Network Upgrade	2015	15,589		20	779	779	779	23
24	Custom Elevator Pit Ladder	2015	10,665		20	533	533	533	24
25	Parking Lot Re-Stripe	2015	7,400		20	370	370	370	25
26	Stairwell Safety Signs	2015	2,591		20	130	130	130	26
27	Thru Wall Air Conditioners	2015	4,207		20	210	210	210	27
28	Office Building	2009	250,000			12,500	12,500	12,500	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,519,733	$		$ 425,987	$ 425,987	$ 2,126,955	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - S.I.R. Management	2009	53,347	1,368	39	1,368		8,264	3
4	Allocated - S.I.R. Properties - S.I.R. Management	1993	48,296	1,533	35	1,380	(153)	31,047	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	12,245	341	20		(341)	12,245	9
10	Allocated - S.I.R. Management	1994	38		20			38	10
11	Allocated - S.I.R. Management	1995	280		20	8	8	280	11
12	Allocated - S.I.R. Management	1997	18,815	421	20	917	496	17,582	12
13	Allocated - S.I.R. Management	1999	1,479		20	74	74	1,201	13
14	Allocated - S.I.R. Management	2000	1,747		20	87	87	1,357	14
15	Allocated - S.I.R. Management	2007	5,612		20	281	281	2,299	15
16	Allocated - S.I.R. Management	2008	15,466	1,547	20	975	(572)	7,647	16
17	Allocated - S.I.R. Management	2009	38,432	351	20	1,922	1,571	11,999	17
18	Allocated - S.I.R. Management	2011	951	95	20	95		420	18
19	Allocated - S.I.R. Management	2012	3,043	152	20	152		520	19
20	Allocated - S.I.R. Management	2014	427	43	20	21	(22)	34	20
21									21
22	Allocated - S.I.R. Properties - S.I.R. Management	2012	2,958	208	20	10	(198)	53	22
23	Allocated - S.I.R. Properties - S.I.R. Management	2010	2,914		20	146	146	777	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2009	2,900	129	20	145	16	986	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2007	846	17	20	42	25	381	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2002	191		20	10	10	130	26
27	Allocated - S.I.R. Properties - S.I.R. Management	1999	6,120		20	306	306	5,049	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1998	2,925		20	146	146	2,559	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1997	182		20	9	9	173	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1994	460	12	20		(12)	460	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1993	783	4	20		(4)	783	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 220,457	$ 6,221		$ 8,094	$ 1,873	$ 106,284	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 220,457	$ 6,221		$ 8,094	$ 1,873	$ 106,284	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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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)		$ 220,457	$ 6,221		$ 8,094	$ 1,873	$ 106,284	34

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,577,203	$ 112,119	$ 158,225	$ 46,106	10	$ 839,999	71
72	Current Year Purchases	3,182	318	318		10	318	72
73	Fully Depreciated Assets	104,330		7	7	10	104,330	73
74								74
75	TOTALS	$ 1,684,715	$ 112,437	$ 158,550	$ 46,113		$ 944,647	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	2015	$ 3,751	$ 328	$ 401	$ 73	5	$ 2,562	76
77										77
78										78
79										79
80	TOTALS			$ 3,751	$ 328	$ 401	$ 73		$ 2,562	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)	$ 26,756,847	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 861,561	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,073,511	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 211,950	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,732,269	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		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,655 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		$	$ 7,772	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,772	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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$ 447,005	$		$ 447,005	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				124,501			124,501	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				648,172			648,172	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					398,619		398,619	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							298,991		298,991	13
14	TOTAL				$		$ 1,219,678	$ 697,610		$ 1,917,288	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 Center, Llc # 0049841 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 31,185	$ 140,984	1
2	Cash-Patient Deposits	85,445	85,445	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,677,221	2,677,221	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,153	215,674	6
7	Other Prepaid Expenses	2,422	2,422	7
8	Accounts Receivable (owners or related parties)	100,000	100,000	8
9	Other(specify):		712,024	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,987,426	$ 3,933,770	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	3,805,994	15
16	Equipment, at Historical Cost	576,007	1,672,269	16
17	Accumulated Depreciation (book methods)	(823,096)	(4,617,757)	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	8,463,406	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,075,527	$ 30,666,447	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,062,953	$ 34,600,217	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 605,578	$ 605,579	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,445	85,445	28
29	Short-Term Notes Payable	2,420,000	2,420,000	29
30	Accrued Salaries Payable	296,629	296,629	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,048	10,048	31
32	Accrued Real Estate Taxes(Sch.IX-B)		906,100	32
33	Accrued Interest Payable		74,570	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	140,622	140,622	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,558,322	$ 4,538,993	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		25,206,650	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)**	$	$ 25,206,650	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,558,322	$ 29,745,643	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,504,631	$ 4,854,574	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,062,953	$ 34,600,217	48

***(See instructions.)**

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,124,610	1
2	Restatements (describe):		2
3	Rounding	(8)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,124,602	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(107,971)	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	(512,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (619,971)	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)**	$ 1,504,631	24 *

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

Facility Name & ID Number Regency Rehabilitation Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 16,355,682	1
2	Discounts and Allowances for all Levels	(3,750,609)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,605,073	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,550,647	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,550,647	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,425	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,134	19
20	Radiology and X-Ray	12,233	20
21	Other Medical Services	79,763	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 437,555	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	518,673	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 518,673	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,124,061	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,717,119	31
32	Health Care	5,545,582	32
33	General Administration	4,029,181	33
	B. Capital Expense		
34	Ownership	3,334,497	34
	C. Ancillary Expense		
35	Special Cost Centers	2,008,803	35
36	Provider Participation Fee	596,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,232,032	40
41	**Income before Income Taxes (line 30 minus line 40)****	(107,971)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (107,971)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,633,595	44
45	Private Pay - Net Inpatient Revenue	1,548,750	45
46	Medicare - Net Inpatient Revenue	496,054	46
47	Other-(specify) Hospice	382,547	47
48	Other-(specify) HMO/Insurance	1,544,127	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,605,073	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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,646	1,803	$ 80,210	$ 44.49	1
2	Assistant Director of Nursing	1,896	2,098	74,526	35.52	2
3	Registered Nurses	29,963	31,862	900,993	28.28	3
4	Licensed Practical Nurses	50,778	54,097	1,312,323	24.26	4
5	CNAs & Orderlies	146,877	157,274	1,807,514	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,251	8,143	149,603	18.37	8
9	Activity Director					9
10	Activity Assistants	21,812	23,280	248,636	10.68	10
11	Social Service Workers	10,057	10,913	167,683	15.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,659	46,251	519,832	11.24	15
16	Dishwashers					16
17	Maintenance Workers	6,976	7,674	151,929	19.80	17
18	Housekeepers	33,542	35,727	350,208	9.80	18
19	Laundry	15,949	17,430	167,413	9.60	19
20	Administrator	3,810	3,887	231,184	59.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,966	21,984	262,407	11.94	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	8,595	9,344	240,793	25.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,504	5,238	146,903	28.05	33
34	TOTAL (lines 1 - 33)	406,281	437,005	$ 6,812,157 *	$ 15.59	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	$ 23,200	01-03	35
36	Medical Director	Monthly	45,500	09-03	36
37	Medical Records Consultant	Monthly	5,096	10-03	37
38	Nurse Consultant	Monthly	93,600	10-03	38
39	Pharmacist Consultant	Monthly	4,510	10-03	39
40	Physical Therapy Consultant	145	7,238	10a-03	40
41	Occupational Therapy Consultant	90	4,482	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	41	2,037	10a-03	43
44	Activity Consultant	Monthly	6,952	11-03	44
45	Social Service Consultant	Monthly	3,752	12-03	45
46	Other(specify) Cardiologist	Monthly	20,000	10-03	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)	275	$ 281,167		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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lea Radunsky	Administrator	0	$ 76,539
Lorrie Butler	Administrator	0	124,062
Catherine Flood	Administrator	0	30,583
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 231,184

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 400,103
SIR Management - Director of Administrative Services	86,400
SIR Management - Ancillary Admin. Charges	72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 558,503
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum	Accounting Fees	$ 22,135
Plante Moran	Accounting Fees	4,970
McGladrey	Accounting Fees	1,455
PayChex	Payroll Services	21,533
SIR Management	Dir. Of Regulatory Services	43,200
SIR Management	Dir. Of Financial Services	48,000
SIR Management	Bookkeeping	147,600
SIR Management	Computer Support	39,600
H.K. Payroll	WOTC Consulting	4,318
Achieve Accreditation	Accreditation	5,652
E-Health Data	Data Processing	3,300
See Supplemental Schedule		111,483
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 453,246

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,534
Unemployment Compensation Insurance	109,421
FICA Taxes	517,943
Employee Health Insurance	536,115
Employee Meals	39,584
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching Contributions	7,472
Other Employee Benefits	22,061
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,372,129

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	$ 1,992
Advertising: Employee Recruitment	3,751
Health Care Worker Background Check	
(Indicate # of checks performed 545)	5,459
Patient Background Checks	
Dues & Subcriptions	26,643
Licenses & Fees	9,957
Allocated from SIR Management	2,241
Advertising and Promotion	49,121
Less: Public Relations Expense	( )
Non-allowable advertising	(49,121)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,043

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,521
Allocated from SIR Management	1,625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,146

**See instructions.

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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			$		$	$	$	$	$	$	$	$	$
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 Center, Llc # 0049841 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: $35026**

(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. $ **47,091** 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. $ **594,780**
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. $ **39,584** 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 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.