

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0040295</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Renaissance Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1675 East Ash Street</u> <u>Canton</u> <u>61520</u>																									
NumberCityZip Code																									
County: <u>Fulton</u>																									
Telephone Number: <u>(309) 647-5631</u> Fax # <u>(309) 647-8957</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>02/01/93</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2	70	Skilled Pediatric (SNF/PED)	70	25,620	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,569	2,569	8
9	SNF/PED	19,943			19,943	9
10	ICF	13,181	1,921	2,641	17,743	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,124	1,921	5,210	40,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.89%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 02/01/1993

J. Was the facility purchased or leased after January 1, 1978? YES X Date 02/01/1993 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 120 and days of care provided 2,569

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	155,347	10,389	18,515	184,251		184,251	(1,128)	183,123			1
2	Food Purchase		164,284		164,284		164,284	(78)	164,206			2
3	Housekeeping	164,200	48,715		212,915		212,915		212,915			3
4	Laundry	91,255	36,575		127,830		127,830		127,830			4
5	Heat and Other Utilities			130,883	130,883		130,883	1,253	132,136			5
6	Maintenance	73,295	54,631	56,637	184,563		184,563	7,062	191,625			6
7	Other (specify):*											7
8	TOTAL General Services	484,097	314,594	206,035	1,004,726		1,004,726	7,109	1,011,835			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,702,102	165,522	10,899	2,878,523		2,878,523	35,180	2,913,703			10
10a	Therapy	9,627	12,099	3,031	24,757		24,757		24,757			10a
11	Activities	90,781	1,769		92,550		92,550		92,550			11
12	Social Services	46,132		5,318	51,450		51,450		51,450			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,294	6,294			15
16	TOTAL Health Care and Programs	2,848,642	179,390	25,248	3,053,280		3,053,280	41,474	3,094,754			16
	C. General Administration											
17	Administrative	86,832		95,088	181,920		181,920	(46,124)	135,796			17
18	Directors Fees											18
19	Professional Services			377,081	377,081		377,081	(338,838)	38,243			19
20	Dues, Fees, Subscriptions & Promotions			38,860	38,860		38,860	(19,615)	19,245			20
21	Clerical & General Office Expenses	72,984	5,367	91,483	169,834		169,834	123,148	292,982			21
22	Employee Benefits & Payroll Taxes			533,408	533,408		533,408		533,408			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,255	7,255		7,255	141	7,396			24
25	Other Admin. Staff Transportation			16,990	16,990		16,990	7,430	24,420			25
26	Insurance-Prop.Liab.Malpractice			105,599	105,599		105,599	2,190	107,789			26
27	Other (specify):*							38,767	38,767			27
28	TOTAL General Administration	159,816	5,367	1,265,764	1,430,947		1,430,947	(232,901)	1,198,046			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,492,555	499,351	1,497,047	5,488,953		5,488,953	(184,318)	5,304,635			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			87,167	87,167		87,167	234,152	321,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,482	77,482		77,482	666,419	743,901			32
33	Real Estate Taxes							63,802	63,802			33
34	Rent-Facility & Grounds			985,648	985,648		985,648	(972,508)	13,140			34
35	Rent-Equipment & Vehicles			7,506	7,506		7,506	7,087	14,593			35
36	Other (specify):*							70,459	70,459			36
37	TOTAL Ownership			1,157,803	1,157,803		1,157,803	69,411	1,227,214			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		427,343	243,511	670,854		670,854		670,854			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,328	396,328		396,328	(62,509)	333,819			42
43	Other (specify):*	30,050		6,575	36,625		36,625	(36,625)				43
44	TOTAL Special Cost Centers	30,050	427,343	646,414	1,103,807		1,103,807	(99,134)	1,004,673			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,522,605	926,694	3,301,264	7,750,563		7,750,563	(214,041)	7,536,522			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,692)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(51,849)	30		9
10	Interest and Other Investment Income	(13,111)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	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	(500)	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	(43,922)	21		24
25	Fund Raising, Advertising and Promotional	(18,320)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,009)	20		28
29	Other-Attach Schedule	(1,548,981)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,686,462)		\$	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)	1,472,421		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,472,421		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (214,041)		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

Report Period Beginning:

Ending:

ID#

0040295

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalized R&M	\$ (15,686)	06	1
2	Marketing	(30,050)	43	2
3	Bank Charges	(3,526)	21	3
4	Theft & Damage Loss	(264)	21	4
5	Building Co. - Accounting Fees	(11,470)	19	5
6	Building Co. - Amortization	(404,634)	31	6
7	Building Co. - Prepayment Penalty	(1,022,355)	21	7
8	PPA - Bed Tax	(62,509)	42	8
9	PPA - Dietary Fees	(1,128)	01	9
10	Non Allowable Legal	(7,391)	19	10
11	Non Allowable Expenses	(6,575)	43	11
12	Marketing Travel	(2,552)	25	12
13	Additional R&M	19,159	06	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,548,981)		49

ID#

0040295

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
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86			37
87			38
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90			41
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93			44
94			45
95			46
96			47
97			48
98			49

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 982,535	Renaissance Care Center Property LLC	100.00%	\$	\$ (982,535)	1
2	V	32	Interest Income	255	Renaissance Care Center Property LLC	100.00%		(255)	2
3	V	19	Accounting Fees		Renaissance Care Center Property LLC	100.00%	11,470	11,470	3
4	V	31	Amortization		Renaissance Care Center Property LLC	100.00%	404,634	404,634	4
5	V	30	Depreciation		Renaissance Care Center Property LLC	100.00%	285,017	285,017	5
6	V	32	Interest Expense		Renaissance Care Center Property LLC	100.00%	679,785	679,785	6
7	V	21	Prepayment Penalty		Renaissance Care Center Property LLC	100.00%	1,022,355	1,022,355	7
8	V	36	MIP Expense		Renaissance Care Center Property LLC	100.00%	70,459	70,459	8
9	V	06	Repairs and Maintenance		Renaissance Care Center Property LLC	100.00%	12,129	12,129	9
10	V	33	Real Estate Taxes		Renaissance Care Center Property LLC	100.00%	63,802	63,802	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 982,790			\$ 2,549,651	\$ * 1,566,861	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	CERTIFIED HEALTH MANAGEMENT	100.00%	\$ 1,253	\$ 1,253	15
16	V	6	AUTO REPAIRS		CERTIFIED HEALTH MANAGEMENT	100.00%	152	152	16
17	V	10	NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	35,180	35,180	17
18	V	15	EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	6,294	6,294	18
19	V	17	ADMINISTRATIVE SALARIES		CERTIFIED HEALTH MANAGEMENT	100.00%	1,764	1,764	19
20	V	19	PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	2,340	2,340	20
21	V	20	DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	214	214	21
22	V	21	SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	147,795	147,795	22
23	V	21	OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	23,065	23,065	23
24	V	24	SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	141	141	24
25	V	25	AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	9,982	9,982	25
26	V	26	INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	2,190	2,190	26
27	V	27	EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	30,176	30,176	27
28	V	30	DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	984	984	28
29	V	34	RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	10,027	10,027	29
30	V	35	AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	7,087	7,087	30
31	V	17	ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	40,000	40,000	31
32	V	17	ADMIN COMP - H. GELLER		CERTIFIED HEALTH MANAGEMENT	100.00%	7,200	7,200	32
33	V	27	EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	7,875	7,875	33
34	V	27	EMP. BEN. - H. GELLER		CERTIFIED HEALTH MANAGEMENT	100.00%	716	716	34
35	V								35
36	V	17	MANAGEMENT FEES	73,380	CERTIFIED HEALTH MANAGEMENT	100.00%		(73,380)	36
37	V	19	BOOKEEPING FEES	333,787	CERTIFIED HEALTH MANAGEMENT	100.00%		(333,787)	37
38	V	17	ADMIN.-CONSULT FEES	21,708	CERTIFIED HEALTH MANAGEMENT	100.00%		(21,708)	38
39	Total			\$ 428,875			\$ 334,435	\$ * (94,440)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BRADLEY ALTER & BETH ALTER	27.675%	DANVILLE CARE CENTER, LTD.	DANVILLE	RENAISSANCE CARE CENTER	SKOKIE	BUILDING CO.	1
2	HOWARD D GELLER & RITA	47.417%	GLENWOOD HEALTHCARE & REHAB, INC.	GLENWOOD	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	JENNIFER CHOW	1.845%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN,INC.	LEWISTOWN				3
4	JULIE BRUM	1.845%						4
5	MR. ARNOLD GASSEL	5.535%						5
6	MR. ELLIOTT ROBINSON	1.661%						6
7	MR. IRA SHYMAN	1.845%						7
8	MR. JOSEPH L ASHMAN	1.845%						8
9	MR. LAURENCE ZUNG	3.506%						9
10	MR. SHELDON ROBINSON	0.554%						10
11	MRS. IRENE SANDLER	2.768%						11
12	RABBI MORRIS NOBLE	1.845%						12
13	SHELDON ROBINSON -LEVITT TRUST	1.661%						13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bradley Alter	Owner	Administration	27.68%	See Attached	10	20.00%	Alloc. Salary	\$ 40,000	17-7	1
2	Howard Geller	Owner	Administration	47.42%	See Attached	3	12.00%	Al. Mgmt Fees	7,200	17-7	2
3											3
4											4
5											5
6											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	\$ 47,200		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 Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CERTIFIED HEALTH MANAGEMENT
Street Address 3856 W. OAKTON
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 674-4700
Fax Number (847) 674-4733

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	144,523	4	\$ 4,499	\$	40,255	\$ 1,253	1
2	6	AUTO REPAIRS	PATIENT DAYS	144,523	4	544		40,255	152	2
3	10	NURSING	PATIENT DAYS	144,523	4	126,303	126,303	40,255	35,180	3
4	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	144,523	4	22,595		40,255	6,294	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	144,523	4	6,333	6,333	40,255	1,764	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	144,523	4	8,400		40,255	2,340	6
7	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	144,523	4	767	530,612	40,255	214	7
8	21	SALARIES - CLERICAL	PATIENT DAYS	144,523	4	530,612		40,255	147,795	8
9	21	OFFICE EXPENSES	PATIENT DAYS	144,523	4	82,807		40,255	23,065	9
10	24	SEMINAR EXPENSE	PATIENT DAYS	144,523	4	505		40,255	141	10
11	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	144,523	4	35,837		40,255	9,982	11
12	26	INSURANCE	PATIENT DAYS	144,523	4	7,862		40,255	2,190	12
13	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	144,523	4	108,336		40,255	30,176	13
14	30	DEPRECIATION	PATIENT DAYS	144,523	4	3,531		40,255	984	14
15	34	RENT	PATIENT DAYS	144,523	4	36,000		40,255	10,027	15
16	35	AUTO LEASE	PATIENT DAYS	144,523	4	25,444		40,255	7,087	16
17	17	ADMIN COMP - B. ALTER	AVG HOURS WORKED	50	4	200,000	200,000	10	40,000	17
18	17	ADMIN COMP - H. GELLER	AVG HOURS WORKED	25	4	60,000	60,000	3	7,200	18
19	27	EMP. BEN. - B. ALTER	AVG HOURS WORKED	50	4	39,376		10	7,875	19
20	27	EMP. BEN. - H. GELLER	AVG HOURS WORKED	25	4	5,966		3	716	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,305,717	\$ 923,248		\$ 334,435	25

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Enloe		X	Note Payable	\$1,444.11	4/7/11	\$ 88,530	\$ 65,848		5.7500	\$ 4,199	1	
2	HUD		X	Mortgage				12,953,426			679,785	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Bank Financial		X	Line of Credit				2,025,505		4.5000	71,856	6	
7	Officers Loan	X						2,414				7	
8	See Supplemental Schedule										1,427	8	
9	TOTAL Facility Related				\$1,444.11		\$ 88,530	\$ 15,047,193			\$ 757,267	9	
	B. Non-Facility Related*												
10	Interest Income		X								(13,111)	10	
11	Interest Income-Bldg Co.		X								(255)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (13,366)	14	
15	TOTALS (line 9+line14)						\$ 88,530	\$ 15,047,193			\$ 743,901	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 70,459 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
6													6	
7	TOTAL Long-Term												7	
	Working Capital													
8	Insurance Financing		X				\$					\$	1,427	8
9													9	
10													10	
11													11	
12													12	
13													13	
14	TOTAL Working Capital											1,427	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2011 report.				\$	58,347 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.)				\$	60,172 2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	1,825 3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	61,977 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.				\$	63,802 7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2007	42,659	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2008	43,651	9																					
		2009	46,135	10																					
		2010	56,648	11																					
		2011	60,172	12																					
2012 Accrual - \$60,172 x 1.03 = \$61,977																									

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Renaissance Care Center	COUNTY	Fulton
---------------	-------------------------	--------	--------

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	09-08-25-101-025	Long-Term Care Property	\$ 60,172.02	\$ 60,172.02
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 60,172.02	\$ 60,172.02

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	X	NO
-----	---	----

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance Care Center COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 291,000	1
2					2
3	TOTALS			\$ 291,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	190		1993	1976	\$ 5,238,000	\$ 209,877	27.5	\$ 190,454	\$ (19,423)	\$ 2,420,079	4	
5				2010	534,152		27.5	19,424	19,424	58,272	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1993	9,646		20	482	482	9,510	9	
10	Various			1994	9,445		20	472	472	8,649	10	
11	Various			1995	11,173		20	559	559	9,776	11	
12	Various			1997	23,578		20	1,179	1,179	18,273	12	
13	Various			1998	47,834		20	2,392	2,392	34,680	13	
14	Various			1999	21,162		20	1,058	1,058	14,549	14	
15	Various			2000	9,146		20	457	457	5,754	15	
16	Various			2001	48,446		20	2,422	2,422	27,856	16	
17	Various			2002	2,252		20	113	113	1,182	17	
18	Various			2003	16,990		20	850	850	8,070	18	
19	Various			2004	4,707		20	235	235	2,000	19	
20	Various			2005	30,220		20	1,511	1,511	11,458	20	
21	Various			2006	52,027		20	2,601	2,601	16,909	21	
22	Various			2007	5,890		20	295	295	1,718	22	
23	Various			2008	23,192		20	2,319	2,319	11,016	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

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)		656,039	53,696		32,804	(20,892)	151,905	67
68	Related Party Allocations (Pages 12H & 12I)		26,245	673		1,312	639	20,996	68
69	Financial Statement Depreciation			87,167			(87,167)		69
70	TOTAL (lines 4 thru 69)		\$ 6,770,144	\$ 351,413		\$ 260,939	\$ (90,474)	\$ 2,832,652	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,770,144	\$ 351,413		\$ 260,939	\$ (90,474)	\$ 2,832,652	1
2	Window Unit Air Conditioners	2010	3,368		20	481	481	1,443	2
3	Pvc Accordion Folding Doors	2010	2,904		20	581	581	1,742	3
4	Pvc Accordion Folding Doors	2010	3,564		20	713	713	2,138	4
5	Door Frames	2010	2,960		20	148	148	407	5
6	Resident Room Signage	2010	2,996		20	599	599	1,498	6
7	Awnings	2010	2,354		20	471	471	1,138	7
8	Circuit Extension	2010	8,500		20	850	850	1,842	8
9	Airway Clearance Device	2011	15,800		20	3,160	3,160	6,320	9
10	Air Pulse Generator System	2011	4,400		20	880	880	1,613	10
11	Thru Wall A/C	2011	7,503		20	1,501	1,501	2,251	11
12	Roof Top Unit	2011	5,000		20	250	250	375	12
13	Roof Top Unit	2011	4,893		20	245	245	347	13
14	Water Heater	2012	6,595		20	165	165	165	14
15	Thru Wall A/C Unit	2012	2,695		20	193	193	193	15
16	Video Monitor System	2012	16,353		20	2,180	2,180	2,180	16
17	Vinyl Flooring, Cove Base - Physical Therapy Room	2012	10,579		20	529	529	529	17
18	Menards - Sink, Faucet, Granite - Therapy Room - 100 Wing	2012	2,657		20	177	177	177	18
19	Walls, Flooring, Millwork, Handrails - Lobby, Activity, Concierge	2012	2,500		20	31	31	31	19
20	Repair Sewer Line	2012	4,314		20	53	53	53	20
21	Sealcoating	2012	6,000		20	75	75	75	21
22	Replace 2 Sets Of Doors - Facility Entry, Front Of Building	2012	5,372		20	22	22	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)		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,891,451	\$ 351,413		\$ 274,242	\$ (77,171)	\$ 2,857,192	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Fire Protection Line	2009	15,714		20	786	786	3,230	9
10	Flooring - Econocare	2009	18,657		20	933	933	11,505	10
11	Windows	2009	96,772		20	4,839	4,839	29,838	11
12	Tile Work	2009	4,000		20	200	200	1,267	12
13	Blacktop	2009	30,000		20	1,500	1,500	6,333	13
14	Masonry	2009	17,860		20	893	893	2,679	14
15	Fire Protection	2010	105,000		20	5,250	5,250	29,750	15
16	Wallcovering, ceramic tile, carpet, laminate nurses station	2010	84,876		20	4,244	4,244	48,096	16
17	ALTA Survey (Engineer)	2010	2,659		20	133	133	753	17
18	Window Treatments	2010	6,379		20	319	319	1,807	18
19	Installation of Shingles	2010	16,650		20	833	833	2,498	19
20	Circuit Extension	2011	8,500		20	425	425	1,700	20
21	Walls,ceiling tile, flooring,millwork,lighting,cabinetry,handrails,w	2012	248,972		20	12,449	12,449	12,449	21
22	Book Depreciation			53,696			(53,696)		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 656,039	\$ 53,696		\$ 32,804	\$ (20,892)	\$ 151,905	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Certified Health Management	1997	26,245	673	20	1,312	639	20,996	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 26,245	\$ 673		\$ 1,312	\$ 639	\$ 20,996	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 261,181	\$ 17,019	\$ 31,659	\$ 14,640	10	\$ 156,461	71
72	Current Year Purchases	119,438	295	10,020	9,725	10	10,020	72
73	Fully Depreciated Assets	536,713		68	68	10	536,713	73
74								74
75	TOTALS	\$ 917,332	\$ 17,314	\$ 41,747	\$ 24,433		\$ 703,194	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		VEHICLES	1996	\$ 5,840	\$	\$	\$	5	\$ 5,840	76
77		VEHICLE	2000	13,900				5	13,900	77
78		VEHICLE	2003	18,859				5	18,859	78
79		Bldg Co. - Used Van	2009	26,648	4,440	5,329	889	5	19,989	79
80	TOTALS			\$ 65,247	\$ 4,440	\$ 5,329	\$ 889		\$ 58,588	80

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,165,030
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 373,167
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 321,318
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (51,849)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,618,973

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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

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	Storage				3,113			5
6	Allocated from Certified Health Management				10,027			6
7	TOTAL				\$ 13,140			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 7,506
- 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 Certified Health Management		\$	\$ 7,087	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,087	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 119,650	\$		\$ 119,650	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,271			15,271	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			108,590			108,590	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				100,265		100,265	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						327,078		327,078	13
14	TOTAL			\$		\$ 243,511	\$ 427,343		\$ 670,854	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 53,226	\$ 178,904	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,187,463	3,187,463	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,707	102,707	6
7	Other Prepaid Expenses	578	49,257	7
8	Accounts Receivable (owners or related parties)	1,206,076	1,206,076	8
9	Other(specify): See Attached Schedule	78,235	204,894	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,628,285	\$ 4,929,301	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		291,000	13
14	Buildings, at Historical Cost		5,772,152	14
15	Leasehold Improvements, at Historical Cost	395,232	1,072,222	15
16	Equipment, at Historical Cost	549,849	952,515	16
17	Accumulated Depreciation (book methods)	(659,029)	(3,621,356)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		533,869	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 286,052	\$ 5,000,402	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,914,337	\$ 9,929,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 713,892	\$ 723,522	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	68,262	68,262	29
30	Accrued Salaries Payable	229,569	229,569	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,508	16,508	31
32	Accrued Real Estate Taxes(Sch.IX-B)		61,977	32
33	Accrued Interest Payable	10,399	48,720	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	81	429,302	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,038,711	\$ 1,577,860	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,025,505	2,025,505	39
40	Mortgage Payable		12,953,426	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		1,060,805	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,025,505	\$ 16,039,736	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,064,216	\$ 17,617,596	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,850,121	\$ (7,687,893)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,914,337	\$ 9,929,703	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,202,220	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,202,221	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(352,100)	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	()	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)	\$ (352,100)	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)	\$ 1,850,121	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,248,430	1
2	Discounts and Allowances for all Levels	(525,760)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,722,670	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	417,524	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 417,524	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	94,501	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,916	19
20	Radiology and X-Ray		20
21	Other Medical Services	140,513	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 243,930	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,111	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,111	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,228	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,228	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,398,463	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,004,726	31
32	Health Care	3,053,280	32
33	General Administration	1,430,947	33
	B. Capital Expense		
34	Ownership	1,157,803	34
	C. Ancillary Expense		
35	Special Cost Centers	707,479	35
36	Provider Participation Fee	396,328	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,750,563	40
41	Income before Income Taxes (line 30 minus line 40)**	(352,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (352,100)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,940,396	44
45	Private Pay - Net Inpatient Revenue	236,565	45
46	Medicare - Net Inpatient Revenue	521,639	46
47	Other-(specify) Managed Care, Hospice	19,015	47
48	Other-(specify) Exceptional Care, Pediatric	4,005,055	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,722,670	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,879	2,358	\$ 82,852	\$ 35.14	1
2	Assistant Director of Nursing	1,968	2,080	58,978	28.35	2
3	Registered Nurses	18,810	20,071	491,393	24.48	3
4	Licensed Practical Nurses	27,989	30,719	693,001	22.56	4
5	CNAs & Orderlies	109,803	116,973	1,327,954	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	854	968	9,627	9.95	8
9	Activity Director	2,504	2,552	33,911	13.29	9
10	Activity Assistants	1,188	1,220	11,151	9.14	10
11	Social Service Workers	3,360	3,525	46,132	13.09	11
12	Dietician					12
13	Food Service Supervisor	1,919	2,080	40,809	19.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,032	4,434	44,432	10.02	15
16	Dishwashers	7,372	7,772	70,106	9.02	16
17	Maintenance Workers	3,767	3,929	73,295	18.65	17
18	Housekeepers	15,150	16,279	164,200	10.09	18
19	Laundry	8,812	9,659	91,255	9.45	19
20	Administrator	1,791	2,080	86,832	41.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,952	2,080	42,422	20.40	23
24	Clerical	2,276	2,465	30,562	12.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,740	2,080	45,719	21.98	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,977	4,293	47,924	11.16	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,492	1,540	30,050	19.51	33
34	TOTAL (lines 1 - 33)	222,635	239,157	\$ 3,522,605 *	\$ 14.73	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	370	\$ 18,515	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	60	2,862	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	125	8,037	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	50	3,031	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	115	4,368	12-03	45
46	Other(specify)				46
47	Psychosocial Consultant	23	950	12-03	47
48					48
49	TOTAL (lines 35 - 48)	743	\$ 43,763		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Renaissance Care Center		STATE OF ILLINOIS		Report Period Beginning:		Page 21	
				# 0040295		01/01/12		Ending: 12/31/12	
XIX. SUPPORT SCHEDULES									
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Marty Jones	Administrator	0	\$ 74,713	Workers' Compensation Insurance		\$ 114,681	IDPH License Fee		\$
LeAnn Thomas	Administrator	0	12,119	Unemployment Compensation Insurance		41,433	Advertising: Employee Recruitment		10,996
				FICA Taxes		265,897	Health Care Worker Background Check		3,000
				Employee Health Insurance		105,178	(Indicate # of checks performed 300)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising & Promotions		19,329
				Pension Plan Contributions		6,220	Dues & Subscriptions		2,666
TOTAL (agree to Schedule V, line 17, col. 1)							Licenses & Permits		2,369
(List each licensed administrator separately.)			\$ 86,832				Allocated from Certified Health Mngmnt		214
B. Administrative - Other									
Description			Amount				Less: Public Relations Expense	(	
Certified Health Management-Management Fees			\$ 73,380				Non-allowable advertising		(18,320)
Certified Health Management-Administrative Consultants			21,708				Yellow page advertising		(1,009)
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 95,088	TOTAL (agree to Schedule V, line 22, col.8)			\$ 533,409	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description		Amount
Vendor/Payee	Type		Amount				Out-of-State Travel		\$
Paychex	Payroll Processing		\$ 10,085						
Certified Health Management	Bookkeeping Fees		333,787						
FR&R	Accounting Fees		10,240						
Richard Peelo	Accounting Fees		3,750				In-State Travel		
Adj on Page 5A	Legal		7,391						
Personnel Planners	Unemployment Consulting		4,903						
Ehealth Data Solutions	MDS Software		4,224						
2401 Incorporated	Arch. Consulting		2,700				Seminar Expense		7,255
							Allocated from Certified Health Mngmnt		141
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense (	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 377,080					(agree to Sch. V, line 24, col. 8)	
								TOTAL	
								\$ 7,396	
				* Attach copy of IMRF notifications			**See instructions.		
SEE ACCOUNTANTS' COMPILATION REPORT									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

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

No
- (2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A
- (3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$3,487

Line

10-2
- (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.

\$333,819

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.

\$

N/A

Has any meal income been offset against related costs?

N/A

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?

No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT