



Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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 \_\_\_\_\_

	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	152	Skilled (SNF)	152	55,480	1
2	42	Skilled Pediatric (SNF/PED)	42	15,330	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	194	TOTALS	194	70,810	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			1,339	1,339	8
9	SNF/PED	17,115			17,115	9
10	ICF	18,149	2,415	81	20,645	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,264	2,415	1,420	39,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.22%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/93 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 1,339

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

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

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	137,770	7,537	4,701	150,008		150,008		150,008		1
2	Food Purchase		242,561		242,561		242,561	(165)	242,396		2
3	Housekeeping	122,565	27,788		150,353		150,353	465	150,818		3
4	Laundry	64,350	25,848		90,198		90,198		90,198		4
5	Heat and Other Utilities			107,874	107,874		107,874		107,874		5
6	Maintenance	43,341	20,060	10,760	74,161		74,161	81	74,242		6
7	Other (specify):*			5,272	5,272		5,272		5,272		7
8	<b>TOTAL General Services</b>	<b>368,026</b>	<b>323,794</b>	<b>128,607</b>	<b>820,427</b>		<b>820,427</b>	<b>381</b>	<b>820,808</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	1,924,103	152,094	5,880	2,082,077		2,082,077	19,196	2,101,273		10
10a	Therapy	19,571	2,967	2,575	25,113		25,113		25,113		10a
11	Activities	33,775	2,074		35,849		35,849		35,849		11
12	Social Services	57,507		6,530	64,037		64,037		64,037		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,034,956</b>	<b>157,135</b>	<b>21,485</b>	<b>2,213,576</b>		<b>2,213,576</b>	<b>19,196</b>	<b>2,232,772</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	56,204		12,000	68,204		68,204	34,466	102,670		17
18	Directors Fees										18
19	Professional Services			71,255	71,255		71,255	(29,243)	42,012		19
20	Dues, Fees, Subscriptions & Promotions			18,283	18,283		18,283	(7,489)	10,794		20
21	Clerical & General Office Expenses	47,422	13,157	160,951	221,530		221,530	(44,778)	176,752		21
22	Employee Benefits & Payroll Taxes			429,302	429,302		429,302	25,549	454,851		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,766	2,766		2,766	3,119	5,885		24
25	Other Admin. Staff Transportation			7,699	7,699		7,699	6,098	13,797		25
26	Insurance-Prop.Liab.Malpractice			138,393	138,393		138,393	2,650	141,043		26
27	Other (specify):*			31,801	31,801		31,801	(31,801)			27
28	<b>TOTAL General Administration</b>	<b>103,626</b>	<b>13,157</b>	<b>872,450</b>	<b>989,233</b>		<b>989,233</b>	<b>(41,429)</b>	<b>947,804</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,506,608</b>	<b>494,086</b>	<b>1,022,542</b>	<b>4,023,236</b>		<b>4,023,236</b>	<b>(21,852)</b>	<b>4,001,384</b>		<b>29</b>

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,701
	REPAIRS & MAINTENANCE	0
		0
		4,701
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	
	ELECTRICITY	84,127
	WATER	23,493
	CABLE TV - LOBBY	254
		0
		107,874
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	4,978
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,870
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,120
	FIRE SERVICE	792
		0
		0
		0
		10,760
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	5,272
	SECURITY SERVICE	0
		5,272
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,500
		6,500

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	2,396
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	1,200
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	664
	PHARMACY CONSULTANT XVIII B 39-2	1,620
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		5,880
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	2,400
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	175
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,575
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	6,530
	SOCIAL WORKER XVIII B 45-2	0
		0
		6,530
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	12,000
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	7,589
	ADMINISTRATIVE CONSULTANTS XIX C	30,967
	PROFESSIONAL FEES XIX C	32,699
		0
		71,255
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,524
	EMPLOYEE WANT ADS XIX F	6,555
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	2,484
	LICENSES & PERMITS XIX F	1,720
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
		18,283
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,535
	OUTSIDE CLERICAL SERVICES	130,130
	PENALTIES / OVERDRAFT CHARGES VI 18	14,898
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	388
	TELEPHONE	10,131
	MESSENGER SERVICE	2,869
		0
		160,951

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	189,923
	UNEMPLOYMENT COMPENSATION XIX D	24,061
	WORKERS COMPENSATION INSURANCI XIX D	118,332
	HOSPITALIZATION INSURANCE XIX D	93,865
	EMPLOYEE BENEFITS - OTHER XIX D	1,059
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	2,062
	CHICAGO HEAD TAX XIX D	0
		429,302
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	985
	TRAVEL XIX G	1,781
		0
		0
		2,766
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	7,699
		7,699
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	138,393
		138,393
27	<b>OTHER</b>	
	BAD DEBTS VI 24	31,801
		0
		31,801

GRAND TOTAL COLUMN 3 OTHER

1,022,542

Facility Name &amp; ID Number

RENAISSANCE CARE CENTER

#0040295

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			36,391	36,391		36,391	228,139	264,530			30
31	Amortization of Pre-Op. & Org.							84,029	84,029			31
32	Interest			(9,619)	(9,619)		(9,619)	525,392	515,773			32
33	Real Estate Taxes			42,408	42,408		42,408		42,408			33
34	Rent-Facility & Grounds			741,654	741,654		741,654	(733,406)	8,248			34
35	Rent-Equipment & Vehicles			572	572		572	427	999			35
36	Other (specify):* storage			400	400		400		400			36
37	<b>TOTAL Ownership</b>			811,806	811,806		811,806	104,581	916,387			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,244	68,920	134,164		134,164		134,164			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,215	106,215		106,215		106,215			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		65,244	175,135	240,379		240,379		240,379			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,506,608	559,330	2,009,483	5,075,421		5,075,421	82,729	5,158,150			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,524)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(14,898)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,801)	27		24
25	Fund Raising, Advertising and Promotional	(7,524)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (55,912)		\$	30

<b>OHF USE ONLY</b>					
48		49		50	
				51	
					52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	138,641		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 138,641		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 82,729		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

RENAISSANCE CARE CENTER

ID# 0040295

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 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			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(165)	0	0	0	0	0	0	0	0	0	0	(165)	2
3	Housekeeping	0	0	465	0	0	0	0	0	0	0	0	465	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	81	0	0	0	0	0	0	0	0	81	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(165)</b>	<b>0</b>	<b>546</b>	<b>0</b>	<b>381</b>	<b>8</b>							
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	19,196	0	0	0	0	0	0	0	0	19,196	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>19,196</b>	<b>0</b>	<b>19,196</b>	<b>16</b>							
<b>C. General Administration</b>														
17	Administrative	0	(12,000)	46,466	0	0	0	0	0	0	0	0	34,466	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(30,967)	1,724	0	0	0	0	0	0	0	0	(29,243)	19
20	Fees, Subscriptions & Promotions	(7,524)	0	35	0	0	0	0	0	0	0	0	(7,489)	20
21	Clerical & General Office Expenses	(14,898)	(126,765)	96,885	0	0	0	0	0	0	0	0	(44,778)	21
22	Employee Benefits & Payroll Taxes	0	0	25,549	0	0	0	0	0	0	0	0	25,549	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,119	0	0	0	0	0	0	0	0	3,119	24
25	Other Admin. Staff Transportation	0	0	6,098	0	0	0	0	0	0	0	0	6,098	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,650	0	0	0	0	0	0	0	0	2,650	26
27	Other (specify):*	(31,801)	0	0	0	0	0	0	0	0	0	0	(31,801)	27
28	<b>TOTAL General Administration</b>	<b>(54,223)</b>	<b>(169,732)</b>	<b>182,526</b>	<b>0</b>	<b>(41,429)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(54,388)</b>	<b>(169,732)</b>	<b>202,268</b>	<b>0</b>	<b>(21,852)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,524)	226,831	2,832	0	0	0	0	0	0	0	0	228,139	30
31	Amortization of Pre-Op. & Org.	0	84,029	0	0	0	0	0	0	0	0	0	84,029	31
32	Interest	0	525,392	0	0	0	0	0	0	0	0	0	525,392	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(741,654)	8,248	0	0	0	0	0	0	0	0	(733,406)	34
35	Rent-Equipment & Vehicles	0	0	427	0	0	0	0	0	0	0	0	427	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,524)</b>	<b>94,598</b>	<b>11,507</b>	<b>0</b>	<b>104,581</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(55,912)</b>	<b>(75,134)</b>	<b>213,775</b>	<b>0</b>	<b>82,729</b>	<b>45</b>							

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SCHEDULE ATTACHED		CERTIFIED HEALTH		BOOKKEEPING
				MANAGEMENT	SKOKIE	MANAGEMENT

**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	17 MANAGEMENT FEES	\$ 12,000	CERTIFIED HEALTH MANAGEMENT		\$	\$ (12,000)	1
2	V	21 BOOKKEEPING FEES	130,130				(130,130)	2
3	V	19 ADMIN CONSULTING FEES	30,967				(30,967)	3
4	V							4
5	V	34 RENT	741,654	RENAISSANCE CARE CENTER LLC			(741,654)	5
6	V	21 OFFICE EXPENSE		" " " "		3,365	3,365	6
7	V	30 DEPRECIATION		" " " "		226,831	226,831	7
8	V	31 AMORTIZATION		" " " "		84,029	84,029	8
9	V	32 INTEREST		" " " "		525,392	525,392	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 914,751			\$ 839,617	\$ * (75,134)	14

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

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	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 465	\$	465	15
16	V	5 ELECTRIC & GAS							16
17	V	6 MAINTENANCE				81		81	17
18	V	10 NURSING/MEDICAL RECORDS				19,196		19,196	18
19	V	17 ADMIN SALARIES				46,466		46,466	19
20	V	19 PROFESSIONAL FEES				1,724		1,724	20
21	V	20 FEE, SUBSCRIPTIONS				35		35	21
22	V	21 OFFICE EXP.				96,885		96,885	22
23	V	22 EMPLOYEE BENEFITS				25,549		25,549	23
24	V	24 TRAVEL/SEMINAR				3,119		3,119	24
25	V	25 TRANSPORTATION				6,098		6,098	25
26	V	26 INSURANCE				2,650		2,650	26
27	V	30 DEPRECIATION				2,832		2,832	27
28	V	32 INTEREST							28
29	V	34 OFFICE RENT				8,248		8,248	29
30	V	35 EQUIPMENT RENTAL				427		427	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		\$			\$ 213,775	\$ *	213,775	39

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

Facility Name & ID Number **RENAISSANCE CARE CENTER** # **0040295** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

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		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	\$ 10,270	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,270		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:

**01/01/2003**

Ending: **2/31/2003**

**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 CERTIFIED HEALTH MANAGEMENT  
 Street Address 3856 OAKTON SUTIE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

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	3	HOUSEKEEPING	PER PATIENT DAY	252,049	8	\$ 3,000	\$ 39,099	\$ 465	1
2	5	ELECTRIC & GAS	" "	252,049	8	0	39,099	0	2
3	6	MAINTENANCE	" "	252,049	8	520	39,099	81	3
4	10	NURSING/MEDICAL RECORDS	" "	252,049	8	123,747	123,747	19,196	4
5	17	ADMIN SALARIES	" "	252,049	8	299,543	299,543	46,466	5
6	19	PROFESSIONAL FEES	" "	252,049	8	11,116	39,099	1,724	6
7	20	FEE, SUBSCRIPTIONS	" "	252,049	8	225	39,099	35	7
8	21	OFFICE EXP.	" "	252,049	8	624,560	542,222	96,885	8
9	22	EMPLOYEE BENEFITS	" "	252,049	8	164,697	39,099	25,549	9
10	24	TRAVEL/SEMINAR	" "	252,049	8	20,108	39,099	3,119	10
11	25	TRANSPORTATION	" "	252,049	8	39,310	39,099	6,098	11
12	26	INSURANCE	" "	252,049	8	17,081	39,099	2,650	12
13	30	DEPRECIATION	" "	252,049	8	18,257	39,099	2,832	13
14	32	INTEREST	" "	252,049	8	0	39,099	0	14
15	34	OFFICE RENT	" "	252,049	8	53,167	39,099	8,248	15
16	35	EQUIPMENT RENTAL	" "	252,049	8	2,754	39,099	427	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,378,085	\$ 965,512	\$ 213,775	25

Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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 RENAISSANCE CARE CENTER LLC  
 Street Address 3856 OAKTON SUITE 200  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number (847) 674-4700  
 Fax Number (847) 674-4733

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>21</u>	<u>OFFICE EXPENSE</u>		<u>1</u>	\$ <u>3,365</u>	\$	<u>1</u>	\$ <u>3,365</u>	<u>1</u>
2	<u>30</u>	<u>DEPRECIATION</u>	<u>1</u>	<u>1</u>	<u>226,831</u>		<u>1</u>	<u>226,831</u>	<u>2</u>
3	<u>31</u>	<u>AMORTIZATION</u>	<u>1</u>	<u>1</u>	<u>84,029</u>		<u>1</u>	<u>84,029</u>	<u>3</u>
4	<u>32</u>	<u>INTEREST</u>	<u>1</u>	<u>1</u>	<u>525,392</u>		<u>1</u>	<u>525,392</u>	<u>4</u>
5									<u>5</u>
6									<u>6</u>
7									<u>7</u>
8									<u>8</u>
9									<u>9</u>
10									<u>10</u>
11									<u>11</u>
12									<u>12</u>
13									<u>13</u>
14									<u>14</u>
15									<u>15</u>
16									<u>16</u>
17									<u>17</u>
18									<u>18</u>
19									<u>19</u>
20									<u>20</u>
21									<u>21</u>
22									<u>22</u>
23									<u>23</u>
24									<u>24</u>
25	<b>TOTALS</b>				\$ <b>839,617</b>	\$		\$ <b>839,617</b>	<b>25</b>

Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CIB BANK		X	MORTGAGE	\$39,927.00	4/00	\$ 4,152,030	\$	TR TO BAN	9.7500	\$ 158,528	1								
2	GERSHON BASSMAN	X		MORTGAGE	\$16,993.00	4/00	1,789,668	1,577,267		9.7500	148,638	2								
3	BANK FINANCIAL		X	MORTGAGE	\$14,812.00	4/00	715,867	359,756			20,822	3								
4	BANK FINANCIAL		X	MORTGAGE				4,593,323			197,404	4								
5												5								
<b>Working Capital</b>																				
6	BANK FINANCIAL		X	WORKING CAPITAL				(329,330)		PRIME+	(10,306)	6								
7	OFFICERS	X		WORKING CAPITAL				4,225			600	7								
8	AICC		X	INS FINANCING							87	8								
9	TOTAL Facility Related				\$71,732.00		\$ 6,657,565	\$ 6,205,241			\$ 515,773	9								
<b>B. Non-Facility Related*</b>																				
10	IRS, IDR, ETC											10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 6,657,565	\$ 6,205,241			\$ 515,773	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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.)

**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 2002 report.	\$	<b>41,437</b>	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.)	\$	<b>41,505</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>68</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>42,340</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>42,408</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	<b>35,422</b>	8
	1999	<b>38,438</b>	9
	2000	<b>39,452</b>	10
	2001	<b>40,625</b>	11
	2002	<b>41,505</b>	12

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.**

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME RENAISSANCE CARE CENTER COUNTY FULTON

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

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

Enter the tax index number and real estate tax assessed for 2002 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 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>09-08-25-101-025</u>	<u>NURSING HOME</u>	\$ <u>41,505.00</u>	\$ <u>41,505.00</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>41,505.00</u>	\$ <u>41,505.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES   X   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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning:

01/01/2003 Ending:

12/31/2003

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories 1

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>			\$ <u>291,000</u>	1
2					2
3	TOTALS			\$ 291,000	3

Facility Name &amp; ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	194	2000		\$ 5,238,000	\$ 190,136	27.5	\$ 190,473	\$ 337	\$ 706,216	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LEASEHOLD IMPROVEMENTS		1993	9,646	303	39	247	(56)	3,125	9
10	LEASEHOLD IMPROVEMENTS		1994	9,445	242	39	242	0	2,245	10
11	TILE,OVERBED FIXTURES, AC		1995	2,316	59	39	59	0	589	11
12	WATER/GAS LINE WORK		1995	6,797	174	39	174	0	1,741	12
13	ROOF REPAIR		1995	2,060	53	39	53	(0)	504	13
14	NURSE STATION		1997	5,222	134	39	134	(0)	947	14
15	ROOF REPAIR		1997	7,235	186	39	186	(0)	1,255	15
16	WATER STORAGE TANK		1997	6,550	168	39	168	(0)	1,144	16
17	CARPET, LIGHT FIXTURES		1997	4,570	117	39	117	0	781	17
18	DOORS		1998	3,264	84	39	84	(0)	475	18
19	ROOFING		1998	7,000	179	39	179	0	947	19
20	WALLPAPER, TILES, BUMPER GUARDS		1998	26,992	692	39	692	0	3,623	20
21	LANDSCAPING, SIDEWALK,FENCE		1998	10,578	271	39	271	0	1,409	21
22	FLOOR/CEILING TILE		1999	8,975	230	39	230	0	1,122	22
23	LANDSCAPING		1999	12,187	312	39	312	0	1,445	23
24	OUTDOOR SIGN		2000	1,023	37	27.5	37	0	137	24
25	ROOF REPAIR		2000	8,123	295	27.5	295	0	958	25
26	ROOFTOP CONDENSER UNITS		2001	4,850	176	27.5	176	0	428	26
27	LIFT		2001	1,396	51	27.5	51	(0)	108	27
28	ROOF IMPROVEMENTS		2001	42,200	1,535	27.5	1,535	(0)	3,390	28
29	SIDEWALK REPLACEMENT		2002	1,152	54	15	77	23	115	29
30	SHOWER ROOM IMPROVEMENTS		2002	1,100	40	27.5	40		60	30
31	TILE		2003	10,875	181	27.5	181		181	31
32	SHOWER ROOM IMPROVEMENTS		2003	2,216	37	27.5	37		37	32
33	ROOF REPAIR		2003	2,800	47	27.5	47		47	33
34	ROOF REPAIR		2003	1,100	18	27.5	18		18	34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 5,437,672	\$ 195,811		\$ 196,117	\$ 306	\$ 733,049	70

\*\*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:

**01/01/2003**

Ending:

**12/31/2003**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-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	\$ 153,222	\$ 16,391	\$ 22,700	\$ 6,309	5-7YRS	\$ 73,538	71
72	Current Year Purchases	15,183	8,949	1,518	(7,431)	5	1,518	72
73	Fully Depreciated Assets	74,446					74,446	73
74	<b>RELATED PARTY</b>		39,530	39,530				74
75	<b>TOTALS</b>	\$ 242,851	\$ 64,870	\$ 63,748	\$ (1,122)		\$ 149,502	75

**D. Vehicle Depreciation (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			1996	\$ 5,840	\$	\$	\$	5	\$ 5,840	76
77			2000	13,900	1,601	2,780	1,179	5	12,788	77
78		2002 CHEVY TRANSP VAN	2003	18,859	3,772	1,886	(1,886)	5	1,886	78
79										79
80	<b>TOTALS</b>			\$ 38,599	\$ 5,373	\$ 4,666	\$ (707)		\$ 20,514	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,010,122	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 266,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,530	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,524)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 903,064	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	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 - RELATED PARTY

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

\*\*

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 572 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2004 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	39-3	hrs	\$		\$ 25,735	\$		\$ 25,735	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,243			7,243	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			35,942			35,942	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts				52,858		52,858	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): <b>LAB SVCS</b>	39-2 39-2					9,247 3,139		9,247 3,139	13
14	<b>TOTAL</b>			\$		\$ 68,920	\$ 65,244		\$ 134,164	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number      RENAISSANCE CARE CENTER

#      0040295

Report Period Beginning:    01/01/2003

Ending:      12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of    12/31/2003

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance      7,343 )	1,066,121		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,833		6
7	Other Prepaid Expenses	27,337		7
8	Accounts Receivable (owners or related parties)	20,979		8
9	Other(specify): <u>R/E TAX ESCROW</u>	14,369		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$    1,170,639	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	199,671		15
16	Equipment, at Historical Cost	281,451		16
17	Accumulated Depreciation (book methods)	(261,560)		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):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$    219,562	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$    1,390,201	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$    620,375	\$	26
27	Officer's Accounts Payable	4,225		27
28	Accounts Payable-Patient Deposits	12,303		28
29	Short-Term Notes Payable	22,815		29
30	Accrued Salaries Payable	6,731		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,495		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,340		32
33	Accrued Interest Payable	6,059		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$    722,343	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$    722,343	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$    667,858	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$    1,390,201	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>506,347</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>506,348</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>161,510</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>161,510</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>667,858</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,082,297	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,082,297	3
<b>B. Ancillary Revenue</b>			
4	Day Care	10,475	4
5	Other Care for Outpatients		5
6	Therapy	138,364	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 148,839	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	138	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 138	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DISCOUNTS</b>	346	28
28a	<b>VENDING COMMISSIONS (NET OF COST)</b>	5,311	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,657	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,236,931	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	820,427	31
32	Health Care	2,213,576	32
33	General Administration	989,233	33
<b>B. Capital Expense</b>			
34	Ownership	811,806	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	134,164	35
36	Provider Participation Fee	106,215	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,075,421	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	161,510	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 161,510	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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	1,525	1,575	\$ 37,287	\$ 23.67	1
2	Assistant Director of Nursing	1,883	2,000	38,621	19.31	2
3	Registered Nurses	6,797	6,842	136,001	19.88	3
4	Licensed Practical Nurses	27,854	28,942	506,576	17.50	4
5	Nurse Aides & Orderlies	103,016	106,046	1,074,608	10.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,825	1,953	19,571	10.02	8
9	Activity Director	2,010	2,080	21,354	10.27	9
10	Activity Assistants	1,956	1,956	12,421	6.35	10
11	Social Service Workers	4,577	4,766	57,507	12.07	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	23,793	11.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,641	6,032	48,339	8.01	15
16	Dishwashers	8,592	9,017	65,638	7.28	16
17	Maintenance Workers	2,029	2,237	43,341	19.37	17
18	Housekeepers	15,320	16,024	122,565	7.65	18
19	Laundry	8,797	9,085	64,350	7.08	19
20	Administrator	2,032	2,080	56,204	27.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,129	2,337	26,263	11.24	23
24	Clerical	2,000	2,072	21,159	10.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,294	3,445	43,345	12.58	28
29	Resident Services Coordinator	2,032	2,080	36,500	17.55	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,017	2,105	21,708	10.31	31
32	Other Health C: <u>Care Plan Coord</u>	1,975	2,080	29,457	14.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,157	216,834	\$ 2,506,608 *	\$ 11.56	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	125	\$ 4,701	1-3	35
36	Medical Director	monthly	6,500	9-3	36
37	Medical Records Consultant	20	664	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly	1,620	10-3	39
40	Physical Therapy Consultant	40	2,400	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	4	175	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	205	6,530	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 22,590		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	40	\$ 1,868	10-3	50
51	Licensed Practical Nurses	16	528	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	56	\$ 2,396		53





Facility Name &amp; ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 106,215  
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 of Public Aid, 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. \$ #REF! Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
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? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees