

		FOR BHF USE			

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I.</p> <p>Facility Name: <u>Renaissance Center</u></p> <p>Address: <u>2800 West Fulton</u> <u>Chicago</u> <u>60612</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 722-2900</u> Fax # _____</p> <p>Federal Employer ID Number: <u>36-4318140</u></p> <p>Date Current Owners were Certified: <u>8/14/2002</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other <u>Limited Partnership</u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2005</u> to <u>12/31/2005</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title)</td> <td><u>Steven N. Lavenda, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address)</td> <td><u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone)</td> <td><u>(847) 236-1111</u> Fax <u>(847) 236-1155</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(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>
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Facility Name Renaissance Center

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	110	Single Unit Apartment	110	40,150	1
2		Double Unit Apartment			2
3		Other			3
4	110	TOTALS	110	40,150	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	30,488	667		31,155	5
6	Double Unit					6
7	Other					7
8	TOTALS	30,488	667		31,155	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 77.60%

D. Indicate the number of paid bed-hold days the SLF had during this year 760 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 220 (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.

(E.g., day care, "meals on wheels", outpatient therapy)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? N/A If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? N/A If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? N/A If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

Facility Name: Renaissance Center

Report Period Beginning:

1/1/2005

Ending: 12/31/2005

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	173,431	155,696	2,914	332,041		332,041	1
2	Housekeeping, Laundry and Maintenance	120,459	12,106	55,325	187,890	(2,427)	185,463	2
3	Heat and Other Utilities			128,066	128,066	(2,063)	126,003	3
4	Other (specify):							4
5	TOTAL General Services	293,890	167,802	186,305	647,997	(4,489)	643,508	5
B. Health Care and Programs								
6	Health Care/ Personal Care	347,677		5,096	352,773		352,773	6
7	Activities and Social Services	33,806		7,238	41,044		41,044	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	381,483		12,334	393,817		393,817	9
C. General Administration								
10	Administrative and Clerical	187,461	10,696	234,464	432,621	101,769	534,390	10
11	Marketing Materials, Promotions and Advertising	81,347		27,068	108,415	(108,415)	0	11
12	Employee Benefits and Payroll Taxes			225,652	225,652	12,195	237,847	12
13	Insurance-Property, Liability and Malpractice			86,005	86,005	3,195	89,200	13
14	Other (specify):	4,111			4,111		4,111	14
15	TOTAL General Administration	272,919	10,696	573,189	856,804	8,745	865,549	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	948,292	178,498	771,828	1,898,618	4,256	1,902,874	16
Capital Expenses								
D. Ownership								
17	Depreciation					1,118	1,118	17
18	Interest			75,595	75,595	(868)	74,727	18
19	Real Estate Taxes			205,650	205,650	(4,113)	201,537	19
20	Rent -- Facility and Grounds					10,304	10,304	20
21	Rent -- Equipment			4,637	4,637	1,783	6,420	21
22	Other (specify):							22
23	TOTAL Ownership			285,882	285,882	8,223	294,105	23
24	GRAND TOTAL (Sum of lines 16 and 23)	948,292	178,498	1,057,710	2,184,500	12,479	2,196,979	24

Facility Name: Renaissance Center

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.50	\$ 34.41	1
2	Licensed Practical Nurses	1.68	27.28	2
3	Certified Nurse Assistants	10.29	10.12	3
4	Activity Director & Assistants	1.00	16.25	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	6.81	12.25	7
8	Dishwashers			8
9	Maintenance Workers	3.51	13.03	9
10	Housekeepers	1.25	9.71	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.43	63.24	13
14	Clerical			14
15	Marketing	1.00	39.11	15
16	Other	0.12	16.22	16
17	Total (lines 1 thru 16)	27.58	\$ 16.53	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached		See Attached	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached		See Attached		See Attached	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ If yes, what is the value of those services? \$ _____

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Renaissance Center

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Allocated From Pathway				\$	\$ 1,644		\$	\$ (1,644)	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Page 5A				-	-		-	-	-	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$ 1,644		\$	\$ (1,644)	\$	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 11,185	\$	\$ 1,119	1,119	10	\$ 2,237	18
19	Vehicles					5	-	19
20	TOTAL (lines 18 and 19)	\$ 11,185	\$	\$ 1,119	1,119		\$ 2,237	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ -	\$ -	\$ -	24

Facility Name & ID Number Renaissance Center

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

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	
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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name: Renaissance Center

Report Period Beginning: 1/1/2005

Ending: 2/31/2005

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5	Allocated From Pathway			/ /	10,304			5
6				/ /				6
7	TOTAL				\$ 10,304			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ 6,420

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	1st Mortgage				/ /	\$	\$ 576,053	/ /		\$ 75,595
2	Note Payable				/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	\$ 576,053			\$ 75,595
	B. Non-Facility Related									
8	Interest Income				/ /			/ /		-748
9	Allocated From Pathway				/ /			/ /		-120
10	TOTALS (lines 7, 8 and 9)					\$	\$ 576,053			\$ 74,727

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Renaissance Center

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

12/31/2005

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 365,773	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	460,067		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,757		6
7	Other Prepaid Expenses	1,432		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	92,254		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 935,283	\$	10
	B. Long-Term Assets			
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			15
16	Equipment, at Historical Cost	11,185		16
17	Accumulated Depreciation (book methods)			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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,185	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 946,468	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 85,945	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,640		30
31	Accrued Taxes Payable	218,077		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	1st Mortgage Principal	(110,847)		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 247,815	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	576,053		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 576,053	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 823,868	\$	45
46	TOTAL EQUITY	\$ 122,600	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 946,468	\$	47

*(See instructions.)

Facility Name: Renaissance Center

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,418,204	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,418,204	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	748	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 748	14
D. Other Revenue (specify):			
15	See Attached	21,469	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 21,469	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,440,421	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	647,997	19
20	Health Care/ Personal Care	393,817	20
21	General Administration	856,804	21
B. Capital Expense			
22	Ownership	285,882	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,184,500	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 255,921	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 255,921	31