

Facility Name & ID Number RENAISSANCE CARE CENTER

0040295 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	132	Skilled (SNF)	132	48,180	1
2	60	Skilled Pediatric (SNF/PED)	60	21,900	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,080	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	2,024		1,020	3,044	8
9	SNF/PED	19,004			19,004	9
10	ICF	16,692	2,556	37	19,285	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,720	2,556	1,057	41,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.98%

D. How many bed-hold days during this year were paid by the Department? 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 1,020

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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
	A. General Services										
1	Dietary	127,165	8,562	16,704	152,431		152,431	0	152,431		1
2	Food Purchase		227,427		227,427	0	227,427	(197)	227,230		2
3	Housekeeping	129,892	44,600	0	174,492		174,492	0	174,492		3
4	Laundry	75,005	23,712	0	98,717	0	98,717	0	98,717		4
5	Heat and Other Utilities			114,823	114,823		114,823	1,368	116,191		5
6	Maintenance	46,318	25,298	13,585	85,201		85,201	1,342	86,543		6
7	Other (specify):*			7,251	7,251		7,251	0	7,251		7
8	TOTAL General Services	378,380	329,599	152,363	860,342	0	860,342	2,513	862,855		8
	B. Health Care and Programs										
9	Medical Director	0		6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	2,066,208	176,841	3,975	2,247,024		2,247,024	25,419	2,272,443		10
10a	Therapy	23,448	3,968	5,025	32,441		32,441	0	32,441		10a
11	Activities	38,150	2,095	363	40,608		40,608	0	40,608		11
12	Social Services	51,235		4,704	55,939		55,939	0	55,939		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	TOTAL Health Care and Programs	2,179,041	182,904	20,067	2,382,012	0	2,382,012	25,419	2,407,431		16
	C. General Administration										
17	Administrative	76,263		23,112	99,375		99,375	37,980	137,355		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			101,730	101,730		101,730	(55,253)	46,477		19
20	Dues, Fees, Subscriptions & Promotions			30,166	30,166		30,166	(7,821)	22,345		20
21	Clerical & General Office Expenses	50,460	16,915	220,578	287,953		287,953	(79,802)	208,151		21
22	Employee Benefits & Payroll Taxes			522,048	522,048	0	522,048	4,977	527,025		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			261	261		261	6,122	6,383		24
25	Other Admin. Staff Transportation			9,846	9,846		9,846	9,802	19,648		25
26	Insurance-Prop.Liab.Malpractice			83,467	83,467		83,467	19,633	103,100		26
27	Other (specify):* Marketing	16,132		0	16,132		16,132	(16,132)	0		27
28	TOTAL General Administration	142,855	16,915	991,208	1,150,978	0	1,150,978	(80,494)	1,070,484		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,700,276	529,418	1,163,638	4,393,332	0	4,393,332	(52,562)	4,340,770		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	16,704
	REPAIRS & MAINTENANCE	0
		0
		16,704
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	0
	ELECTRICITY	81,139
	WATER	32,908
	CABLE TV - LOBBY	776
		0
		114,823
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,293
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,249
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	812
	FIRE SERVICE	1,231
		0
		0
		0
		0
		13,585
7	OTHER	
	SCAVENGER	7,251
	SECURITY SERVICE	0
		0
		0
		7,251
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	501
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,854
	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
		3,975
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	178
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	17
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	4,830
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		5,025
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	363
		0
		363
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,704
		0
		4,704
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	23,112
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,786
	ADMINISTRATIVE CONSULTANTS XIX C	45,378
	PROFESSIONAL FEES XIX C	47,566
		0
		101,730
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,374
	EMPLOYEE WANT ADS XIX F	17,455
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	1,430
	LICENSES & PERMITS XIX F	3,460
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	447
	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
	PATIENT BACKGROUND CHECKS XIX F	0
		30,166
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,620
	OUTSIDE CLERICAL SERVICES	184,767
	PENALTIES / OVERDRAFT CHARGES VI 18	21,564
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	165
	TELEPHONE	9,596
	MESSENGER SERVICE	2,866
		0
		220,578

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	203,923
	UNEMPLOYMENT COMPENSATION XIX D	47,816
	WORKERS COMPENSATION INSURANC XIX D	136,654
	HOSPITALIZATION INSURANCE XIX D	117,558
	EMPLOYEE BENEFITS - OTHER XIX D	356
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	12,530
	PENSION/PROFIT SHARING PLANS XIX D	3,211
	CHICAGO HEAD TAX XIX D	0
		0
		522,048
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	202
	TRAVEL XIX G	59
		261
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	9,846
		9,846
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	83,467
		83,467
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,163,638

RENAISSANCE CARE CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	227,427	PATIENT MEALS	0
LESS SALES TAX	(197)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	227,230	TOTAL MEALS/YEAR	0
TOTAL PATIENT CENSUS	0	NET FOOD	227230
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	0

TOTAL PATIENT MEALS	0	COST PER MEAL	0
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number

RENAISSANCE CARE CENTER

#0040295

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	
	D. Ownership											
30	Depreciation			22,762	22,762		22,762	213,709	236,471			30
31	Amortization of Pre-Op. & Org.			0	0		0	14,123	14,123			31
32	Interest			22,281	22,281		22,281	771,045	793,326			32
33	Real Estate Taxes			44,126	44,126		44,126	0	44,126			33
34	Rent-Facility & Grounds			332,132	332,132		332,132	(339,936)	(7,804)			34
35	Rent-Equipment & Vehicles			6,543	6,543		6,543	0	6,543			35
36	Other (specify):* storage			360	360		360	0	360			36
37	TOTAL Ownership			428,204	428,204	0	428,204	658,941	1,087,145			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		35,416	182,467	217,883		217,883	0	217,883			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			105,120	105,120		105,120	0	105,120			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	35,416	287,587	323,003	0	323,003	0	323,003			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,700,276	564,834	1,879,429	5,144,539	0	5,144,539	606,379	5,750,918			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,573)	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	(197)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(21,564)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	(12,530)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(7,374)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(447)	20		28
29	Other-Attach Schedule		27		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,685)		\$ 0	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	2	
		Amount	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)	685,747		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 685,747		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 637,062		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
		Yes	No	Amount	Reference
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	TOTAL (C): (sum of lines 38-46)			\$	47

RENAISSANCE CARE CENTER

ID# 0040295

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	LEGAL FEES	(14,551)	19	2
3	MARKETING SALARY	(16,132)	27	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	Total	(30,683)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	(197)	0	0	0	0	0	0	0	0	0	0	(197)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,368	0	0	0	0	0	0	0	0	1,368	5
6	Maintenance	0	0	1,342	0	0	0	0	0	0	0	0	1,342	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(197)	0	2,710	0	2,513	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	25,419	0	0	0	0	0	0	0	0	25,419	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	CNA 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	TOTAL Health Care and Programs	0	0	25,419	0	25,419	16							
	C. General Administration													
17	Administrative	0	(23,112)	61,092	0	0	0	0	0	0	0	0	37,980	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,551)	(45,378)	4,676	0	0	0	0	0	0	0	0	(55,253)	19
20	Fees, Subscriptions & Promotions	(7,821)	0	0	0	0	0	0	0	0	0	0	(7,821)	20
21	Clerical & General Office Expenses	(21,564)	(184,405)	126,167	0	0	0	0	0	0	0	0	(79,802)	21
22	Employee Benefits & Payroll Taxes	(12,530)	0	17,507	0	0	0	0	0	0	0	0	4,977	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,122	0	0	0	0	0	0	0	0	6,122	24
25	Other Admin. Staff Transportation	0	0	9,802	0	0	0	0	0	0	0	0	9,802	25
26	Insurance-Prop.Liab.Malpractice	0	0	19,633	0	0	0	0	0	0	0	0	19,633	26
27	Other (specify):*	(16,132)	0	0	0	0	0	0	0	0	0	0	(16,132)	27
28	TOTAL General Administration	(72,598)	(252,895)	244,999	0	(80,494)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,795)	(252,895)	273,128	0	(52,562)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	(6,573)	216,444	3,838	0	0	0	0	0	0	0	0	213,709	30
31	Amortization of Pre-Op. & Org.	0	14,123	0	0	0	0	0	0	0	0	0	14,123	31
32	Interest	0	771,045	0	0	0	0	0	0	0	0	0	771,045	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(346,782)	6,846	0	0	0	0	0	0	0	0	(339,936)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,573)	654,830	10,684	0	658,941	37							
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(79,368)	401,935	283,812	0	606,379	45							

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		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT
				RENAISSANCE CARE CENTER LLC	SKOKIE	REAL ESTATE

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 23,112	CERTIFIED HEALTH MANAGEMENT		\$	\$ (23,112)	1
2	V	21 BOOKKEEPING	184,767				(184,767)	2
3	V	19 ADMIN CONSULTING FEES	45,378				(45,378)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	346,782	RENAISSANCE CARE CENTER LLC			(346,782)	7
8	V	21 OFFICE EXPENSE				362	362	8
9	V	30 DEPRECIATION				216,444	216,444	9
10	V	31 AMORTIZATION				14,123	14,123	10
11	V	32 INTEREST				771,045	771,045	11
12	V							12
13	V							13
14	Total		\$ 600,039			\$ 1,001,974	\$ * 401,935	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		\$ 0	\$	15
16	V	5 ELECTRIC/GAS		" " "		1,368		1,368 16
17	V	6 MAINTENANCE		" " "		1,342		1,342 17
18	V	10 NURSING/MEDICAL RECORDS		" " "		25,419		25,419 18
19	V	17 ADMIN SALARIES		" " "		61,092		61,092 19
20	V	19 PROFESSIONAL FEES		" " "		4,676		4,676 20
21	V	20 FEES, SUBSCRIPTIONS		" " "		0		0 21
22	V	21 OFFICE EXP		" " "		126,167		126,167 22
23	V	22 EMPLOYEE BENEFITS		" " "		17,507		17,507 23
24	V	24 TRAVEL/SEMINAR		" " "		6,122		6,122 24
25	V	25 TRANSPORTATION		" " "		9,802		9,802 25
26	V	26 INSURANCE		" " "		19,633		19,633 26
27	V	30 DEPRECIATION		" " "		3,838		3,838 27
28	V	32 INTEREST		" " "		0		0 28
29	V	34 OFFICE RENT		" " "		6,846		6,846 29
30	V	36 EQUIPMENT RENTAL		" " "		0		0 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		\$			\$ 283,812	\$ *	283,812 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:

01/01/2006

Ending:

12/31/2006

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	\$ 22,380	17-3	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	\$ 22,380		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: **01/01/2006**

Ending: **2/31/2006**

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 3865 OAKTON SUITE 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	199,244	8	\$ 0	41,333	\$ 0	1
2	5	ELECTRIC/GAS	" " "	199,244	8	6,594	41,333	1,368	2
3	6	MAINTENANCE	" " "	199,244	8	6,467	41,333	1,342	3
4	10	NURSING/MEDICAL RECORDS	" " "	199,244	8	122,529	41,333	25,419	4
5	17	ADMIN SALARIES	" " "	199,244	8	294,492	41,333	61,092	5
6	19	PROFESSIONAL FEES	" " "	199,244	8	22,540	41,333	4,676	6
7	20	FEES, SUBSCRIPTIONS	" " "	199,244	8		41,333	0	7
8	21	OFFICE EXP	" " "	199,244	8	608,185	41,333	126,167	8
9	22	EMPLOYEE BENEFITS	" " "	199,244	8	84,392	41,333	17,507	9
10	24	TRAVEL/SEMINAR	" " "	199,244	8	29,513	41,333	6,122	10
11	25	TRANSPORTATION	" " "	199,244	8	47,249	41,333	9,802	11
12	26	INSURANCE	" " "	199,244	8	94,640	41,333	19,633	12
13	30	DEPRECIATION	" " "	199,244	8	18,500	41,333	3,838	13
14	32	INTEREST	" " "	199,244	8	0	41,333	0	14
15	34	OFFICE RENT	" " "	199,244	8	33,000	41,333	6,846	15
16	36	EQUIPMENT RENTAL	" " "	199,244	8	0	41,333	0	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,368,101	\$ 962,154	\$ 283,812	25

Facility Name & ID Number **RENAISSANCE CARE CENTER**

0040295 Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

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	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	30	DEPRECIATION	DIRECT COSTS	1	1	\$ 216,444	\$ 1	\$ 216,444	1
2	31	AMORTIZATION		1	1	14,123	1	14,123	2
3	32	INTEREST		1	1	771,045	1	771,045	3
4	21	OFFICE EXPENSE		1	1	362	1	362	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					\$ 1,001,974	\$	\$ 1,001,974	25

Facility Name & ID Number

RENAISSANCE CARE CENTER

0040295

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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		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							
Working Capital																		
6	INS FINANCING		X							2,411	6							
7	BANK FINANCIAL		X	WORKING CAPITAL			873,903		PRIME+	19,870	7							
8											8							
9	TOTAL Facility Related					\$ 0	\$ 873,903			\$ 22,281	9							
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0	14							
15	TOTALS (line 9+line14)					\$ 0	\$ 873,903			\$ 22,281	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 2005 report.		\$	46,950	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.)		\$	45,086	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,864)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	45,990	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.		\$	44,126	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	40,625	8
	2002	41,505	9
	2003	43,850	10
	2004	46,026	11
	2005	45,086	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2005 TAX BILL.

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.

Facility Name & ID Number RENAISSANCE CARE CENTER

0040295

Report Period Beginning:

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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? 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:

A. Land.

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

Facility Name & ID Number RENAISSANCE CARE CENTER

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Report Period Beginning:

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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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	192	2000		\$ 5,238,000	\$ 216,444	27.5	\$ 190,473	\$ (25,971)	\$ 1,277,298	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LEASEHOLD IMPROVEMENTS		1993	9,646	303	39	247	(56)	3,866	9
10	LEASEHOLD IMPROVEMENTS		1994	9,445	242	39	242	0	2,971	10
11	TILE,OVERBED FIXTURES, AC		1995	2,316	59	39	59	0	766	11
12	WATER/GAS LINE WORK		1995	6,797	174	39	174	0	2,263	12
13	ROOF REPAIR		1995	2,060	53	39	53	(0)	660	13
14	NURSE STATION		1997	5,222	134	39	134	(0)	1,349	14
15	ROOF REPAIR		1997	7,235	186	39	186	(0)	1,813	15
16	WATER STORAGE TANK		1997	6,550	168	39	168	(0)	1,648	16
17	CARPET, LIGHT FIXTURES		1997	4,570	117	39	117	0	1,132	17
18	DOORS		1998	3,264	84	39	84	(0)	727	18
19	ROOFING		1998	7,000	179	39	179	0	1,484	19
20	WALLPAPER, TILES, BUMPER GUARDS		1998	26,992	692	39	692	0	5,699	20
21	LANDSCAPING, SIDEWALK,FENCE		1998	10,578	271	39	271	0	2,222	21
22	FLOOR/CEILING TILE		1999	8,975	230	39	230	0	1,812	22
23	LANDSCAPING		1999	12,187	312	39	312	0	2,391	23
24	OUTDOOR SIGN		2000	1,023	37	27.5	37	0	248	24
25	ROOF REPAIR		2000	8,123	295	27.5	295	0	1,843	25
26	ROOFTOP CONDENSER UNITS		2001	4,850	176	27.5	176	0	956	26
27	LIFT		2001	1,396	51	27.5	51	(0)	261	27
28	ROOF IMPROVEMENTS		2001	42,200	1,535	27.5	1,535	(0)	7,995	28
29	SIDEWALK REPLACEMENT		2002	1,152	54	15	77	23	346	29
30	SHOWER ROOM IMPROVEMENTS		2002	1,100	40	27.5	40		180	30
31	TILE		2003	10,875	395	27.5	395	0	1,366	31
32	SHOWER ROOM IMPROVEMENTS		2003	2,216	81	27.5	81	(0)	280	32
33	ROOF REPAIR		2003	2,800	102	27.5	102	(0)	353	33
34	ROOF REPAIR		2003	1,100	40	27.5	40		138	34
35	COILWORK		2004	1,530	28	27.5	56	28	84	35
36	FIRE SYSTEM WORK		2004	3,177	143	27.5	116	(27)	174	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	PARKING LOT BLACKTOP	2005	\$ 15,000	\$ 545	27.5	\$ 545	\$ 0	\$ 818	37
38	WALL A/C UNITS	2005	9,995	363	27.5	363	0	545	38
39	WALLPAPER	2005	5,225	1,672	5	1,045	(627)	1,568	39
40	ROOFTOP AC UNIT-KITCHEN	2006	14,500	242	27.5	264	22	264	40
41	HANDRAILS	2006	9,311	155	27.5	169	14	169	41
42	WALL A/C UNITS	2006	5,216	87	27.5	95	8	95	42
43	SIDEWALKS	2006	1,713	29	27.5	31	2	31	43
44	NURSES STATION	2006	1,496	25	27.5	27	2	27	44
45	ROOF REPAIR/REPLACE - PARTIAL	2006	23,000	383	27.5	418	35	418	45
46	COMPRESSOR REPLACEMENT	2006	1,365	23	27.5	25	2	25	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)		\$ 5,529,200	\$ 226,149		\$ 199,605	\$ (26,544)	\$ 1,326,286	70

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

Facility Name & ID Number **RENAISSANCE CARE CENTER**

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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	\$ 194,342	\$ 10,164	\$ 28,791	\$ 18,627	5-7	\$ 160,111	71
72	Current Year Purchases	4,622	718	462	(256)	5	462	72
73	Fully Depreciated Assets	114,443	0		0		114,443	73
74			3,840	3,840	0			74
75	TOTALS	\$ 313,407	\$ 14,722	\$ 33,094	\$ 18,372		\$ 275,017	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	\$ 0		\$ 0	5	\$ 5,840	76
77			2000	13,900	0		0	5	13,900	77
78	PATIENT TRANSP	2002 CHEVY TRANSP VAN	2003	18,859	2,173	3,772	1,599	5	13,202	78
79							0			79
80	TOTALS			\$ 38,599	\$ 2,173	\$ 3,772	\$ 1,599		\$ 32,942	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)	\$ 6,172,206	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 243,044	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,471	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,573)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,634,245	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	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 6,543 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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs 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>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 CNA _____</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 CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 81,762	\$		\$ 81,762	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,393			13,393	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			87,312			87,312	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				32,907		32,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): laboratory						2,509		2,509	13
14	TOTAL			\$		\$ 182,467	\$ 35,416		\$ 217,883	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.

Facility Name & ID Number **RENAISSANCE CARE CENTER**

0040295

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2006**

(last day of reporting year)

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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>58,914</u>)	1,335,176		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,873		6
7	Other Prepaid Expenses	13,637		7
8	Accounts Receivable (owners or related parties)	3,393,756		8
9	Other(specify): <u>r/e tax escrow</u>	7,706		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,799,148	\$ 0	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	291,198		15
16	Equipment, at Historical Cost	310,980		16
17	Accumulated Depreciation (book methods)	(343,985)		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): <u>repl tax dep</u>	14,216		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 272,409	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,071,557	\$ 0	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,428,698	\$	26
27	Officer's Accounts Payable	4,225		27
28	Accounts Payable-Patient Deposits	10,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,751		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,374		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,990		32
33	Accrued Interest Payable	16,184		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>line of credit</u>	873,903		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,544,125	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,544,125	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,527,432	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,071,557	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,764,194	1
2	Restatements (describe):		2
3	prior year adj - allowance for bad debt	(52,241)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,711,953	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	815,479	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)	\$ 815,479	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,527,432	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,625,113	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,625,113	3
	B. Ancillary Revenue		
4	Day Care	11,748	4
5	Other Care for Outpatients		5
6	Therapy	233,559	6
7	Oxygen	38,539	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 283,846	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	prior year adj	32,856	28
28a	transp/vending net of costs	18,181	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 51,037	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,960,018	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	860,342	31
32	Health Care	2,382,012	32
33	General Administration	1,150,978	33
	B. Capital Expense		
34	Ownership	428,204	34
	C. Ancillary Expense		
35	Special Cost Centers	217,883	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,144,539	40
41	Income before Income Taxes (line 30 minus line 40)**	815,479	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 815,479	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: 01/01/2006

Ending: 12/31/2006

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	1,712	2,080	\$ 51,987	\$ 24.99	1
2	Assistant Director of Nursing	1,944	2,080	48,485	23.31	2
3	Registered Nurses	11,829	11,992	269,369	22.46	3
4	Licensed Practical Nurses	23,783	24,531	467,444	19.06	4
5	CNAs & Orderlies	98,565	101,071	1,092,187	10.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,915	2,057	23,448	11.40	8
9	Activity Director	1,976	2,080	22,796	10.96	9
10	Activity Assistants	2,110	2,184	15,354	7.03	10
11	Social Service Workers	3,741	4,086	51,235	12.54	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	25,167	12.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,667	4,137	36,289	8.77	15
16	Dishwashers	7,227	7,959	65,709	8.26	16
17	Maintenance Workers	2,153	2,297	46,318	20.16	17
18	Housekeepers	15,135	15,908	129,892	8.17	18
19	Laundry	9,140	9,468	75,005	7.92	19
20	Administrator	1,896	2,080	76,263	36.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,003	2,187	27,131	12.41	23
24	Clerical	1,936	2,088	23,329	11.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,948	2,080	30,752	14.78	28
29	Resident Services Coordinator	1,864	2,080	39,096	18.80	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,970	2,150	24,304	11.30	31
32	Other Health C: Care Plan Coord	1,952	2,080	42,584	20.47	32
33	Other(specify) <u>Marketing</u>	1,020	1,040	16,132	15.51	33
34	TOTAL (lines 1 - 33)	201,342	209,795	\$ 2,700,276 *	\$ 12.87	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	M	\$ 16,704	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,854	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,620	10-3	39
40	Physical Therapy Consultant	L	178	10a-3	40
41	Occupational Therapy Consultant	Y	17	10a-3	41
42	Respiratory Therapy Consultant		4,830	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	363	11-3	44
45	Social Service Consultant	E	4,704	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,270		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295Report Period Beginning: 01/01/2006Ending: 12/31/2006**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? _____
- (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. \$ _____ 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 during this cost report period. \$ 105,120
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. \$ 0 Has any meal income been offset against related costs? N/A 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