



Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 8/28/2007

	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)	120	46,668	1
2	60	Skilled Pediatric (SNF/PED)	70	23,160	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	190	69,828	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	2,413		1,581	3,994	8
9	SNF/PED	19,110			19,110	9
10	ICF	17,115	2,190	95	19,400	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,638	2,190	1,676	42,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.87%

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 2/1/1993

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 2/1/1993 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 1,581

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number RENAISSANCE CARE CENTER # 0040295 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	128,506	9,271	18,293	156,070		156,070		156,070		1
2	Food Purchase		263,129		263,129		263,129	(237)	262,892		2
3	Housekeeping	140,304	55,347		195,651		195,651		195,651		3
4	Laundry	84,195	15,893		100,088		100,088		100,088		4
5	Heat and Other Utilities			163,825	163,825		163,825	1,610	165,435		5
6	Maintenance	48,949	32,349	10,622	91,920		91,920		91,920		6
7	Other (specify):*			7,344	7,344		7,344		7,344		7
8	<b>TOTAL General Services</b>	<b>401,954</b>	<b>375,989</b>	<b>200,084</b>	<b>978,027</b>		<b>978,027</b>	<b>1,373</b>	<b>979,400</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,114,086	194,332	3,647	2,312,065		2,312,065	44,266	2,356,331		10
10a	Therapy	24,333	10,427	5,418	40,178		40,178		40,178		10a
11	Activities	45,109	2,075	747	47,931		47,931		47,931		11
12	Social Services	62,416		4,280	66,696		66,696		66,696		12
13	CNA Training										13
14	Program Transportation			10,891	10,891		10,891		10,891		14
15	Other (specify):* <b>Nsg benefit alloc</b>							7,966	7,966		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,245,944</b>	<b>206,834</b>	<b>30,983</b>	<b>2,483,761</b>		<b>2,483,761</b>	<b>52,232</b>	<b>2,535,993</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	79,416		56,592	136,008		136,008	(5,497)	130,511		17
18	Directors Fees										18
19	Professional Services			141,017	141,017		141,017	(91,875)	49,142		19
20	Dues, Fees, Subscriptions & Promotions			23,625	23,625		23,625	(8,060)	15,565		20
21	Clerical & General Office Expenses	55,125	13,881	184,790	253,796		253,796	(23,611)	230,185		21
22	Employee Benefits & Payroll Taxes			573,949	573,949		573,949	(19,731)	554,218		22
23	Inservice Training & Education										23
24	Travel and Seminar			976	976		976	6,593	7,569		24
25	Other Admin. Staff Transportation			3,742	3,742		3,742	15,367	19,109		25
26	Insurance-Prop.Liab.Malpractice			100,728	100,728		100,728	8,506	109,234		26
27	Other (specify):* <b>admin benefit alloc</b>							9,195	9,195		27
28	<b>TOTAL General Administration</b>	<b>134,541</b>	<b>13,881</b>	<b>1,085,419</b>	<b>1,233,841</b>		<b>1,233,841</b>	<b>(109,113)</b>	<b>1,124,728</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,782,439</b>	<b>596,704</b>	<b>1,316,486</b>	<b>4,695,629</b>		<b>4,695,629</b>	<b>(55,508)</b>	<b>4,640,121</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	18,293
	REPAIRS & MAINTENANCE	0
		0
		18,293
<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	20,191
	ELECTRICITY	107,248
	WATER	36,386
	CABLE TV - LOBBY	0
		0
		163,825
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	5,378
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,516
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,092
	FIRE SERVICE	1,636
		0
		0
		0
		0
		10,622
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	7,344
	SECURITY SERVICE	0
		0
		0
		7,344
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	200
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,962
	PHARMACY CONSULTANT XVIII B 39-2	1,485
	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
		3,647
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	14
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	5,404
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		5,418
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	747
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		747
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,280
		0
		4,280
<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	10,891
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	56,592
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	8,959
	ADMINISTRATIVE CONSULTANTS XIX C	48,744
	PROFESSIONAL FEES XIX C	83,314
		0
		141,017
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	7,505
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE WANT ADS XIX F	10,024
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	0
	LICENSES & PERMITS XIX F	4,291
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	555
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	750
	PATIENT BACKGROUND CHECKS XIX F	500
		23,625
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,514
	OUTSIDE CLERICAL SERVICES	156,780
	PENALTIES / OVERDRAFT CHARGES VI 18	5,484
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,421
	MESSENGER SERVICE/POSTAGE	2,591
		0
		176,790

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	211,704
	UNEMPLOYMENT COMPENSATION XIX D	47,743
	WORKERS COMPENSATION INSURANC XIX D	122,767
	HOSPITALIZATION INSURANCE XIX D	144,358
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	42,800
	PENSION/PROFIT SHARING PLANS XIX D	4,577
	CHICAGO HEAD TAX XIX D	0
		0
		573,949
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	911
	TRAVEL XIX G	65
		976
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	3,742
		3,742
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	100,728
		100,728
27	<b>OTHER</b>	
	BAD DEBTS VI 24	8,000
		8,000

GRAND TOTAL COLUMN 3 OTHER

1,316,486

**RENAISSANCE CARE CENTER  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	263,129
LESS SALES TAX	<u>(237)</u>
NET FOOD	262,892

TOTAL PATIENT CENSUS	42,504
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	127,512

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	127,512
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	127,512

NET FOOD	262,892
DIVIDE TOTAL MEALS/YEAR	<u>127,512</u>

COST PER MEAL	2.06
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			19,970	19,970		19,970	200,612	220,582		30
31	Amortization of Pre-Op. & Org.							14,123	14,123		31
32	Interest			56,911	56,911		56,911	634,470	691,381		32
33	Real Estate Taxes			42,518	42,518		42,518		42,518		33
34	Rent-Facility & Grounds			869,220	869,220		869,220	(859,640)	9,580		34
35	Rent-Equipment & Vehicles			6,276	6,276		6,276		6,276		35
36	Other (specify):* <b>STORAGE</b>			630	630		630	67	697		36
37	<b>TOTAL Ownership</b>			995,525	995,525		995,525	(10,368)	985,157		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		45,198	293,509	338,707		338,707		338,707		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			105,120	105,120		105,120		105,120		42
43	Other (specify):* <b>repl tax/mktg</b>	32,325		9,100	41,425		41,425		41,425		43
44	<b>TOTAL Special Cost Centers</b>	32,325	45,198	407,729	485,252		485,252		485,252		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,814,764	641,902	2,719,740	6,176,406		6,176,406	(65,876)	6,110,530		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>BHF 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	(6,838)	30		9
10	Interest and Other Investment Income	(39)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	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	(5,484)	21		18
19	Entertainment	(7,505)	20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance	(42,800)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,000)	21		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(555)	20		28
29	Other-Attach Schedule <u>marketing</u>	(46,967)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (118,425)		\$	30

<b>BHF 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)	52,549		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 52,549		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (65,876)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	LEGAL FEES	(46,967)	19 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>	(46,967)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(237)	0	0	0	0	0	0	0	0	0	0	(237)	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	1,610	0	0	0	0	0	0	0	0	1,610	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(237)</b>	<b>0</b>	<b>1,610</b>	<b>0</b>	<b>1,373</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	44,266	0	0	0	0	0	0	0	0	44,266	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	7,966	0	0	0	0	0	0	0	0	7,966	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>52,232</b>	<b>0</b>	<b>52,232</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	(56,592)	51,095	0	0	0	0	0	0	0	0	(5,497)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(46,967)	(48,744)	3,836	0	0	0	0	0	0	0	0	(91,875)	19
20	Fees, Subscriptions & Promotions	(8,060)	0	0	0	0	0	0	0	0	0	0	(8,060)	20
21	Clerical & General Office Expenses	(13,484)	(156,333)	146,206	0	0	0	0	0	0	0	0	(23,611)	21
22	Employee Benefits & Payroll Taxes	(42,800)	0	23,069	0	0	0	0	0	0	0	0	(19,731)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,593	0	0	0	0	0	0	0	0	6,593	24
25	Other Admin. Staff Transportation	0	0	15,367	0	0	0	0	0	0	0	0	15,367	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,506	0	0	0	0	0	0	0	0	8,506	26
27	Other (specify):*	0	0	9,195	0	0	0	0	0	0	0	0	9,195	27
28	<b>TOTAL General Administration</b>	<b>(111,311)</b>	<b>(261,669)</b>	<b>263,867</b>	<b>0</b>	<b>(109,113)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(111,548)</b>	<b>(261,669)</b>	<b>317,709</b>	<b>0</b>	<b>(55,508)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(6,838)	203,458	3,992	0	0	0	0	0	0	0	0	200,612	30
31	Amortization of Pre-Op. & Org.	0	14,123	0	0	0	0	0	0	0	0	0	14,123	31
32	Interest	(39)	634,509	0	0	0	0	0	0	0	0	0	634,470	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(869,220)	9,580	0	0	0	0	0	0	0	0	(859,640)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	67	0	0	0	0	0	0	0	0	67	36
37	<b>TOTAL Ownership</b>	<b>(6,877)</b>	<b>(17,130)</b>	<b>13,639</b>	<b>0</b>	<b>(10,368)</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</b> (sum of lines 29, 37 & 44)	<b>(118,425)</b>	<b>(278,799)</b>	<b>331,348</b>	<b>0</b>	<b>(65,876)</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		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG
					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:	
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	\$ 56,592	CETIFIED HEALTH MANAGEMENT		\$	\$ (56,592)	1
2	V	21 BOOKKEEPING	156,780	"			(156,780)	2
3	V	19 ADMIN CONSULTING FEES	48,744	"			(48,744)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	869,220	RENAISSANCE CARE CENTER LLC			(869,220)	7
8	V	21 OFFICE EXPENSE		"		447	447	8
9	V	30 DEPRECIATION		"		203,458	203,458	9
10	V	31 AMORTIZATION		"		14,123	14,123	10
11	V	32 INTEREST		"		634,509	634,509	11
12	V							12
13	V							13
14	Total		\$ 1,131,336			\$ 852,537	\$ * (278,799)	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		" " "		1,610		16
17	V	6 MAINTENANCE		" " "		0		17
18	V	10 NURSING/MEDICAL RECORDS		" " "		44,266		18
19	V	15 NURSING BENEFITS		" " "		7,966		19
20	V	17 ADMIN SALARIES		" " "		51,095		20
21	V	19 PROFESSIONAL FEES		" " "		3,836		21
22	V	20 FEES, SUBSCRIPTIONS		" " "		0		22
23	V	21 OFFICE EXP		" " "		146,206		23
24	V	22 EMPLOYEE BENEFITS		" " "		23,069		24
25	V	24 TRAVEL/SEMINAR		" " "		6,593		25
26	V	25 TRANSPORTATION		" " "		15,367		26
27	V	26 INSURANCE		" " "		8,506		27
28	V	27 ADMIN BENEFITS		" " "		9,195		28
29	V	30 DEPRECIATION		" " "		3,992		29
30	V	32 INTEREST		" " "		0		30
31	V	34 OFFICE RENT		" " "		9,580		31
32	V	36 EQUIPMENT RENTAL		" " "		67		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 331,348	\$ *	331,348 39

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

Facility Name &amp; ID Number

RENAISSANCE CARE CENTER

#

0040295

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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			ALLOC SALA	\$ 41,592	17-7	1
2	HOWARD GELLER		ADMINISTRATION		SEE ATTACHED SCHEDULE			ALLOC FEES	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,592		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: **01/01/2007**

Ending: **2/31/2007**

**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 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	4	\$ 0	\$	42,504	\$ 0	1
2	5	ELECTRIC/GAS	" " "	4	6,050		42,504	1,610	2
3	6	MAINTENANCE	" " "	4	0		42,504	0	3
4	10	NURSING/MEDICAL RECORDS	" " "	4	166,338	166,338	42,504	44,266	4
5	15	NURSING BENEFITS	" " "	4	29,933		42,504	7,966	5
6	17	ADMIN SALARIES	" " "	4	192,000	192,000	42,504	51,095	6
7	19	PROFESSIONAL FEES	" " "	4	14,414		42,504	3,836	7
8	20	FEES, SUBSCRIPTIONS	" " "	4	0	0	42,504	0	8
9	21	OFFICE EXP	" " "	4	549,397	481,726	42,504	146,206	9
10	22	EMPLOYEE BENEFITS	" " "	4	86,688		42,504	23,069	10
11	24	TRAVEL/SEMINAR	" " "	4	24,776		42,504	6,593	11
12	25	TRANSPORTATION	" " "	4	57,744		42,504	15,367	12
13	26	INSURANCE	" " "	4	31,963		42,504	8,506	13
14	27	ADMIN BENEFITS	" " "	4	34,551		42,504	9,195	14
15	30	DEPRECIATION	" " "	4	15,000		42,504	3,992	15
16	32	INTEREST	" " "	4	0		42,504	0	16
17	34	OFFICE RENT	" " "	4	36,000		42,504	9,580	17
18	36	EQUIPMENT RENTAL	" " "	4	250		42,504	67	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,245,104	\$ 840,064		\$ 331,348	25

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

# **0040295** Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

**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	\$ 203,458	\$ 1	\$ 203,458	1
2	31	AMORTIZATION		1	1	14,123	1	14,123	2
3	32	INTEREST		1	1	634,509	1	634,509	3
4	21	OFFICE EXPENSE		1	1	447	1	447	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					\$ 852,537	\$	\$ 852,537	25

Facility Name & ID Number

RENAISSANCE CARE CENTER

# 0040295

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	INS FINANCING		X									4,151	6					
7	BANK FINANCIAL		X	WORKING CAPITAL						PRIME+		52,760	7					
8													8					
9	TOTAL Facility Related						\$	\$			\$	56,911	9					
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES									10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$		14					
15	TOTALS (line 9+line14)						\$	\$			\$	56,911	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 2006 report.	\$	<b>45,990</b>	<b>1</b>
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>43,718</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(2,272)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>44,790</b>	<b>4</b>
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>	\$		<b>5</b>
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>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>42,518</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>41,505</b>	<b>8</b>
	2003	<b>43,850</b>	<b>9</b>
	2004	<b>46,026</b>	<b>10</b>
	2005	<b>45,086</b>	<b>11</b>
	2006	<b>43,718</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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 2006 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:

01/01/2007 Ending:

12/31/2007

**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	<b>TOTALS</b>			\$ <b>291,000</b>	3

Facility Name & ID Number **RENAISSANCE CARE CENTER**# **0040295**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$ 203,458	27.5	\$ 190,473	\$ (12,985)	\$ 1,467,771	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		LEASEHOLD IMPROVEMENTS	1993		9,646	301	39	247	(54)	4,113	9
10		LEASEHOLD IMPROVEMENTS	1994		9,445	245	39	242	(3)	3,213	10
11		TILE,OVERBED FIXTURES, AC	1995		2,316	59	39	59	0	825	11
12		WATER/GAS LINE WORK	1995		6,797	174	39	174	0	2,437	12
13		ROOF REPAIR	1995		2,060	53	39	53	(0)	713	13
14		NURSE STATION	1997		5,222	84	39	134	50	1,483	14
15		ROOF REPAIR	1997		7,235	117	39	186	69	1,999	15
16		WATER STORAGE TANK	1997		6,550	106	39	168	62	1,816	16
17		CARPET, LIGHT FIXTURES	1997		4,570	74	39	117	43	1,249	17
18		DOORS	1998		3,264	16	39	84	68	811	18
19		ROOFING	1998		7,000	35	39	179	144	1,663	19
20		WALLPAPER, TILES, BUMPER GUARDS	1998		26,992	133	39	692	559	6,391	20
21		LANDSCAPING, SIDEWALK,FENCE	1998		10,578	52	39	271	219	2,493	21
22		FLOOR/CEILING TILE	1999		8,975	231	39	230	(1)	2,042	22
23		LANDSCAPING	1999		12,187	297	39	312	15	2,703	23
24		OUTDOOR SIGN	2000		1,023	37	27.5	37	0	285	24
25		ROOF REPAIR	2000		8,123	295	27.5	295	0	2,138	25
26		ROOFTOP CONDENSER UNITS	2001		4,850	176	27.5	176	0	1,132	26
27		LIFT	2001		1,396	51	27.5	51	(0)	312	27
28		ROOF IMPROVEMENTS	2001		42,200	1,535	27.5	1,535	(0)	9,530	28
29		SIDEWALK REPLACEMENT	2002		1,152	54	15	77	23	423	29
30		SHOWER ROOM IMPROVEMENTS	2002		1,100	40	27.5	40		220	30
31		TILE	2003		10,875	395	27.5	395	0	1,761	31
32		SHOWER ROOM IMPROVEMENTS	2003		2,216	81	27.5	81	(0)	361	32
33		ROOF REPAIR	2003		2,800	102	27.5	102	(0)	455	33
34		ROOF REPAIR	2003		1,100	40	27.5	40		178	34
35		COILWORK	2004		1,530	28	27.5	56	28	140	35
36		FIRE SYSTEM WORK	2004		3,177	143	27.5	116	(27)	290	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	2	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	\$ 1,363	37
38	WALL A/C UNITS	2005	9,995	363	27.5	363	0	908	38
39	WALLPAPER	2005	5,225	1,003	5	1,045	42	2,613	39
40	ROOFTOP AC UNIT-KITCHEN	2006	14,500	527	27.5	527	0	791	40
41	HANDRAILS	2006	9,311	339	27.5	339	(0)	508	41
42	WALL A/C UNITS	2006	5,216	190	27.5	190	(0)	285	42
43	SIDEWALKS	2006	1,713	62	27.5	62	0	93	43
44	NURSES STATION	2006	1,496	54	27.5	54	0	81	44
45	ROOF REPAIR/REPLACE - PARTIAL	2006	23,000	836	27.5	836	0	1,254	45
46	COMPRESSOR REPLACEMENT	2006	1,365	50	27.5	50	(0)	75	46
47	SECURITY SYSTEM	2007	1,565	2	20	7	5	7	47
48	DOORS	2007	1,662	9	20	21	12	21	48
49	ROOF TOP AC UNIT	2007	5,890	120	20	245	125	245	49
50	DRAINAGE SYSTEM KITCHEN	2007	1,805	25	20	52	27	52	50
51	SIDEWALKS	2007	1,500	24	20	50	26	50	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)		\$ 5,541,622	\$ 212,561		\$ 201,010	\$ (11,551)	\$ 1,527,295	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:

**01/01/2007**

Ending:

**12/31/2007**

**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	\$ 198,964	\$ 7,142	\$ 11,398	\$ 4,256	5-7	\$ 171,971	71
72	Current Year Purchases	7,762	1,553	410	(1,143)	5	410	72
73	Fully Depreciated Assets	74,756					74,756	73
74			3,992	3,992				74
75	<b>TOTALS</b>	\$ 281,482	\$ 12,687	\$ 15,800	\$ 3,113		\$ 247,137	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				5	13,900	77
78	PATIENT TRANSP	2002 CHEVY TRANSP VAN	2003	18,859	2,172	3,772	1,600	5	16,974	78
79										79
80	<b>TOTALS</b>			\$ 38,599	\$ 2,172	\$ 3,772	\$ 1,600		\$ 36,714	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)	\$ 6,152,703	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 227,420	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 220,582	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,838)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,811,146	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: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			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: \$ 6,276 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	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_/2008 \$ \_\_\_\_\_

13. \_\_\_\_\_/2009 \$ \_\_\_\_\_

14. \_\_\_\_\_/2010 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	CNA 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 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)	
<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 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	\$		\$ 118,335	\$		\$ 118,335	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,885			11,885	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			163,289			163,289	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				42,526		42,526	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>laboratory</b>						2,672		2,672	13
14	<b>TOTAL</b>			\$		\$ 293,509	\$ 45,198		\$ 338,707	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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 <u>84,852</u> )	1,623,077		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,388		6
7	Other Prepaid Expenses	45,780		7
8	Accounts Receivable (owners or related parties)	277,453		8
9	Other(specify): <u>r/e escrow</u>	8,726		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,997,424	\$	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	303,621		15
16	Equipment, at Historical Cost	318,741		16
17	Accumulated Depreciation (book methods)	(363,955)		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>	6,417		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 264,824	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,262,248	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,055,634	\$	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	216,994		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,130		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,790		32
33	Accrued Interest Payable	20,725		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>due to llc</u>	335,550		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,700,048	\$	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 (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,700,048	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 562,200	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,262,248	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,527,432</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Bad debt inter co and operating</b>	<b>(2,225,867)</b>	<b>3</b>
<b>4</b>	<b>Bad debt</b>	<b>(30,167)</b>	<b>4</b>
<b>5</b>	<b>Accrued Vacation</b>	<b>(62,949)</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>208,449</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>353,751</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>353,751</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>562,200</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	\$ 6,076,368	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,076,368	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	1,255	4
5	Other Care for Outpatients		5
6	Therapy	370,172	6
7	Oxygen	36,000	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 407,427	8
	<b>C. Other Operating Revenue</b>		
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	<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***	39	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 39	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>transp/vending net of cost</u>	4,802	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,802	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,488,636	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	978,027	31
32	Health Care	2,483,761	32
33	General Administration	1,233,841	33
	<b>B. Capital Expense</b>		
34	Ownership	995,525	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	380,132	35
36	Provider Participation Fee	105,120	36
	<b>D. Other Expenses (specify):</b>		
37	<u>OUT-OF-PERIOD EXPENSES</u>	(41,521)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,134,885	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	353,751	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 353,751	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: 01/01/2007

Ending: 12/31/2007

**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	1,864	2,080	\$ 58,742	\$ 28.24	1
2	Assistant Director of Nursing	1,736	2,080	52,426	25.20	2
3	Registered Nurses	10,621	10,945	235,210	21.49	3
4	Licensed Practical Nurses	25,340	26,492	511,748	19.32	4
5	CNAs & Orderlies	97,743	99,244	1,114,546	11.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,944	2,095	24,333	11.61	8
9	Activity Director	1,912	2,080	21,913	10.54	9
10	Activity Assistants	2,990	3,078	23,196	7.54	10
11	Social Service Workers	5,842	6,168	62,416	10.12	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	25,542	12.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,850	4,174	37,514	8.99	15
16	Dishwashers	7,287	7,655	65,450	8.55	16
17	Maintenance Workers	2,107	2,307	48,949	21.22	17
18	Housekeepers	14,464	15,414	140,304	9.10	18
19	Laundry	10,398	10,978	84,195	7.67	19
20	Administrator	1,868	2,080	79,416	38.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,950	2,186	32,745	14.98	23
24	Clerical	2,253	2,428	22,380	9.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,876	2,080	31,535	15.16	28
29	Resident Services Coordinator	1,864	2,080	40,061	19.26	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,938	2,122	24,565	11.58	31
32	Other Health C: <u>CARE PLAN</u>	1,960	2,080	45,253	21.76	32
33	Other(specify) <u>MARKETING</u>	1,928	2,080	32,325	15.54	33
34	TOTAL (lines 1 - 33)	205,591	214,006	\$ 2,814,764 *	\$ 13.15	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	\$ 18,293	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,962	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,485	10-3	39
40	Physical Therapy Consultant	L	14	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		5,404	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,280	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,438		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	0	\$ 0	10-3	50
51	Licensed Practical Nurses	0	0	10-3	51
52	Certified Nurse Assistants/Aides	0	0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name & ID Number RENAISSANCE CARE CENTER# 0040295Report Period Beginning: 01/01/2007Ending: 12/31/2007**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? 100% of line  
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 \$5,000, 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