

Facility Name & ID Number Renaissance Care Center

0040295 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2	70	Skilled Pediatric (SNF/PED)	70	25,550	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	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	22,697	197	4,045	26,939	8
9	SNF/PED					9
10	ICF	14,471	1,646	397	16,514	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,168	1,843	4,442	43,453	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.66%

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

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

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

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

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 02/01/1993

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 3,166

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: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,958	11,087	17,445	189,490		189,490		189,490		1
2	Food Purchase		179,017		179,017		179,017	(76)	178,941		2
3	Housekeeping	178,951	49,589		228,540		228,540		228,540		3
4	Laundry	74,163	26,517		100,680		100,680		100,680		4
5	Heat and Other Utilities			117,908	117,908		117,908	1,241	119,149		5
6	Maintenance	76,804	76,843	41,385	195,032		195,032	17,822	212,854		6
7	Other (specify):*										7
8	TOTAL General Services	490,876	343,053	176,738	1,010,667		1,010,667	18,987	1,029,654		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,744,868	136,592	9,971	2,891,431		2,891,431	32,371	2,923,802		10
10a	Therapy	14,511	11,792	2,311	28,614		28,614		28,614		10a
11	Activities	133,009	3,696		136,705		136,705		136,705		11
12	Social Services	31,034		4,493	35,527		35,527		35,527		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,629	6,629		15
16	TOTAL Health Care and Programs	2,923,422	152,080	22,775	3,098,277		3,098,277	39,000	3,137,277		16
	C. General Administration										
17	Administrative	99,285		95,088	194,373		194,373	(55,088)	139,285		17
18	Directors Fees										18
19	Professional Services			311,762	311,762		311,762	(267,345)	44,417		19
20	Dues, Fees, Subscriptions & Promotions			56,803	56,803		56,803	(45,886)	10,917		20
21	Clerical & General Office Expenses	91,082	6,917	1,942,587	2,040,586		2,040,586	(1,673,842)	366,744		21
22	Employee Benefits & Payroll Taxes			544,002	544,002		544,002		544,002		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,372	10,372		10,372	2,016	12,388		24
25	Other Admin. Staff Transportation			31,781	31,781		31,781	12,064	43,845		25
26	Insurance-Prop.Liab.Malpractice			86,869	86,869		86,869	1,708	88,577		26
27	Other (specify):*							52,085	52,085		27
28	TOTAL General Administration	190,367	6,917	3,079,264	3,276,548		3,276,548	(1,974,288)	1,302,260		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,604,665	502,050	3,278,777	7,385,492		7,385,492	(1,916,301)	5,469,191		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Renaissance Care Center

#0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			110,732	110,732		110,732	238,354	349,086			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,267	53,267		53,267	423,311	476,578			32
33	Real Estate Taxes							62,023	62,023			33
34	Rent-Facility & Grounds			804,930	804,930		804,930	(791,770)	13,160			34
35	Rent-Equipment & Vehicles			7,720	7,720		7,720	7,944	15,664			35
36	Other (specify):*							65,049	65,049			36
37	TOTAL Ownership			976,649	976,649		976,649	4,911	981,560			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		518,951	417,387	936,338		936,338		936,338			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			348,075	348,075		348,075		348,075			42
43	Other (specify):*	52,591			52,591		52,591	(52,591)				43
44	TOTAL Special Cost Centers	52,591	518,951	765,462	1,337,004		1,337,004	(52,591)	1,284,413			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,657,256	1,021,001	5,020,888	9,699,145		9,699,145	(1,963,981)	7,735,164			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,965)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(75,625)	30		9
10	Interest and Other Investment Income	(33,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(40)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,202)	21		24
25	Fund Raising, Advertising and Promotional	(44,911)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(893)	20		28
29	Other-Attach Schedule	(1,845,259)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,095,697)		\$	30

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)	131,716		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 131,716		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,963,981)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY					
48		49		50	51
					52

Renaissance Care Center

ID# 0040295

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Liason	\$ (52,591)	43	1
2	Bank Charges	(3,440)	21	2
3	Theft and Damage Loss	(102)	21	3
4	Non-allowable Expense	(129,650)	21	4
5	Forgiveness of related party balance	(1,669,700)	21	5
6	Additional R&M	27,200	06	6
7	Non-Allowable Legal	(5,720)	19	7
8	Prior Period Adjustment	(4,134)	10	8
9				9
10				10
11				11
12	Building Co.			12
13	Accounting Fees	(7,700)	19	13
14	Legal Fees	(1,711)	19	14
15	Amortization	(2,803)	31	15
16	Additional R&M	5,092	06	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	(1,845,259)	49

Renaissance Care Center

ID# 0040295

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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													1
2	Food Purchase	(76)											(76)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,241									1,241	5
6	Maintenance	17,327		495									17,822	6
7	Other (specify):*													7
8	TOTAL General Services	17,251		1,736									18,987	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,134)		36,505									32,371	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,629									6,629	15
16	TOTAL Health Care and Programs	(4,134)		43,134									39,000	16
	C. General Administration													
17	Administrative			(55,088)									(55,088)	17
18	Directors Fees													18
19	Professional Services	(15,131)	9,411	(261,625)									(267,345)	19
20	Fees, Subscriptions & Promotions	(46,304)		418									(45,886)	20
21	Clerical & General Office Expenses	(1,883,134)		209,292									(1,673,842)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,016									2,016	24
25	Other Admin. Staff Transportation			12,064									12,064	25
26	Insurance-Prop.Liab.Malpractice			1,708									1,708	26
27	Other (specify):*			52,085									52,085	27
28	TOTAL General Administration	(1,944,569)	9,411	(39,130)									(1,974,288)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,931,452)	9,411	5,740									(1,916,301)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13 Ending:

12/31/13

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	(75,625)	311,727	2,252									238,354	30
31	Amortization of Pre-Op. & Org.	(2,803)	2,803											31
32	Interest	(33,226)	456,537										423,311	32
33	Real Estate Taxes		62,023										62,023	33
34	Rent-Facility & Grounds		(802,165)	10,395									(791,770)	34
35	Rent-Equipment & Vehicles			7,944									7,944	35
36	Other (specify):*		65,049										65,049	36
37	TOTAL Ownership	(111,654)	95,974	20,591									4,911	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(52,591)											(52,591)	43
44	TOTAL Special Cost Centers	(52,591)											(52,591)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,095,697)	105,385	26,331									(1,963,981)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 802,165	Renaissance Care Center Property LLC	100.00%	\$	\$ (802,165)	1
2	V	32 Interest Income	79	Renaissance Care Center Property LLC	100.00%		(79)	2
3	V	19 Accounting Fees		Renaissance Care Center Property LLC	100.00%	7,700	7,700	3
4	V	31 Amortization		Renaissance Care Center Property LLC	100.00%	2,803	2,803	4
5	V	30 Depreciation		Renaissance Care Center Property LLC	100.00%	311,727	311,727	5
6	V	32 Interest Expense		Renaissance Care Center Property LLC	100.00%	456,616	456,616	6
7	V	33 Real Estate Taxes		Renaissance Care Center Property LLC	100.00%	62,023	62,023	7
8	V	36 MIP Expense		Renaissance Care Center Property LLC	100.00%	65,049	65,049	8
9	V	19 Legal Fees		Renaissance Care Center Property LLC	100.00%	1,711	1,711	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 802,244			\$ 907,629	\$ * 105,385	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CERTIFIED HEALTH MANAGEMENT	100.00%	\$ 1,241	\$	1,241	15
16	V	6 AUTO REPAIRS		CERTIFIED HEALTH MANAGEMENT	100.00%	495		495	16
17	V	10 NURSING		CERTIFIED HEALTH MANAGEMENT	100.00%	36,505		36,505	17
18	V	15 EMP. BEN. HEALTHCARE		CERTIFIED HEALTH MANAGEMENT	100.00%	6,629		6,629	18
19	V	17 ADMINISTRATIVE SALARIES		CERTIFIED HEALTH MANAGEMENT	100.00%				19
20	V	19 PROFESSIONAL FEES		CERTIFIED HEALTH MANAGEMENT	100.00%	14,375		14,375	20
21	V	20 DUES, FEES, SUBSCRIPTIONS		CERTIFIED HEALTH MANAGEMENT	100.00%	418		418	21
22	V	21 SALARIES - CLERICAL		CERTIFIED HEALTH MANAGEMENT	100.00%	183,826		183,826	22
23	V	21 OFFICE EXPENSES		CERTIFIED HEALTH MANAGEMENT	100.00%	25,466		25,466	23
24	V	24 SEMINAR EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	2,016		2,016	24
25	V	25 AUTO & TRAVEL EXPENSE		CERTIFIED HEALTH MANAGEMENT	100.00%	12,064		12,064	25
26	V	26 INSURANCE		CERTIFIED HEALTH MANAGEMENT	100.00%	1,708		1,708	26
27	V	27 EMP. BEN. GEN. ADMIN.		CERTIFIED HEALTH MANAGEMENT	100.00%	42,024		42,024	27
28	V	30 DEPRECIATION		CERTIFIED HEALTH MANAGEMENT	100.00%	2,252		2,252	28
29	V	34 RENT		CERTIFIED HEALTH MANAGEMENT	100.00%	10,395		10,395	29
30	V	35 AUTO LEASE		CERTIFIED HEALTH MANAGEMENT	100.00%	7,944		7,944	30
31	V	17 ADMIN COMP - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	40,000		40,000	31
32	V	27 EMP. BEN. - B. ALTER		CERTIFIED HEALTH MANAGEMENT	100.00%	10,061		10,061	32
33	V								33
34	V								34
35	V								35
36	V	17 MANAGEMENT FEES	73,380	CERTIFIED HEALTH MANAGEMENT	100.00%			(73,380)	36
37	V	19 BOOKEEPING FEES	276,000	CERTIFIED HEALTH MANAGEMENT	100.00%			(276,000)	37
38	V	17 ADMIN.-CONSULT FEES	21,708	CERTIFIED HEALTH MANAGEMENT	100.00%			(21,708)	38
39	Total		\$ 371,088			\$ 397,419	\$ *	26,331	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (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		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BRADLEY ALTER & BETH ALTER	37.0849	DANVILLE CARE CENTER, LTD.	DANVILLE	RENAISSANCE CARE CENTER	SKOKIE	BUILDING CO.	1
2	HOWARD D GELLER & RITA	47.417%	GLENWOOD HEALTHCARE & REHAB, INC.	GLENWOOD	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	MR. LAURENCE ZUNG	3.506%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN, INC.	LEWISTOWN				3
4	MRS. IRENE SANDLER	2.768%						4
5	MR. IRA SHYMAN	1.845%						5
6	MR. JOSEPH L ASHMAN	1.845%						6
7	RABBI MORRIS NOBLE	1.845%						7
8	JENNIFER CHOW	1.845%						8
9	JULIE BRUM	1.845%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 M. Alter	Owner	Administration	37.0849	See Attached	10	20.00%	Alloc. Salary	\$ 40,000	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 40,000		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 W. OAKTON
 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	5	UTILITIES	PATIENT DAYS	150,493	4	\$ 4,296	\$ 43,454	\$ 1,241	1	
2	6	AUTO REPAIRS	PATIENT DAYS	150,493	4	1,713	43,454	495	2	
3	10	NURSING	PATIENT DAYS	150,493	4	126,427	126,427	36,505	3	
4	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	150,493	4	22,957	43,454	6,629	4	
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	150,493	4	-	43,454		5	
6	19	PROFESSIONAL FEES	PATIENT DAYS	150,493	4	49,785	43,454	14,375	6	
7	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	150,493	4	1,446	43,454	418	7	
8	21	SALARIES - CLERICAL	PATIENT DAYS	150,493	4	636,638	636,638	183,826	8	
9	21	OFFICE EXPENSES	PATIENT DAYS	150,493	4	88,194	43,454	25,466	9	
10	24	SEMINAR EXPENSE	PATIENT DAYS	150,493	4	6,981	43,454	2,016	10	
11	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	150,493	4	41,780	43,454	12,064	11	
12	26	INSURANCE	PATIENT DAYS	150,493	4	5,915	43,454	1,708	12	
13	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	150,493	4	145,541	43,454	42,024	13	
14	30	DEPRECIATION	PATIENT DAYS	150,493	4	7,801	43,454	2,252	14	
15	34	RENT	PATIENT DAYS	150,493	4	36,000	43,454	10,395	15	
16	35	AUTO LEASE	PATIENT DAYS	150,493	4	27,513	43,454	7,944	16	
17	17	ADMIN COMP - B. ALTER	AVG HOURS WORKED	50	4	200,000	200,000	10	40,000	17
18	27	EMP. BEN. - B. ALTER	AVG HOURS WORKED	50	4	50,305		10	10,061	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,453,292	\$ 963,065	\$ 397,419		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Enloe		X	Note Payable	\$1,444.11	4/7/11	\$ 88,530	\$ 36,460		5.7500	\$ 2,309	1						
2	HUD		X	Mortgage				12,784,519			456,616	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank Financial		X	Line of Credit				295,599		4.5000	49,489	6						
7	Insurance Financing		X								1,469	7						
8	See Supplemental Schedule							2,414				8						
9	TOTAL Facility Related				\$1,444.11		\$ 88,530	\$ 13,118,992			\$ 509,883	9						
B. Non-Facility Related*																		
10	Interest Income		X								(33,226)	10						
11	Interest Income- Build Co		X								(79)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (33,305)	14						
15	TOTALS (line 9+line14)						\$ 88,530	\$ 13,118,992			\$ 476,578	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 65,049 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
Working Capital																
8	Officer's Loan	X					\$	\$ 2,414			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital							2,414								
B. Non-Facility Related*																
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$	61,977		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.)		\$	61,084		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	(893)		3														
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,916		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.		\$	62,023		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>43,651</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>46,135</u>	9																
	2010	<u>56,648</u>	10																
	2011	<u>60,172</u>	11																
	2012	<u>61,084</u>	12																
2012 Accrual - \$61,084 x 1.03 = \$62,916																			

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Renaissance Care Center

0040295 Report Period Beginning:

01/01/13 Ending:

12/31/13

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	Facility			\$ 291,000	1
2					2
3	TOTALS			\$ 291,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190	1993	1976	\$ 5,238,000	\$ 233,765	27.5	\$ 190,454	\$ (43,311)	\$ 2,610,533	4
5			2010	534,152		27.5	19,424	19,424	77,696	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	9,646		20	136	136	9,646	9
10	Various		1994	9,445		20	472	472	9,121	10
11	Various		1995	11,173		20	559	559	10,335	11
12	Various		1997	23,578		20	1,179	1,179	19,452	12
13	Various		1998	47,834		20	2,392	2,392	37,071	13
14	Various		1999	21,162		20	1,058	1,058	15,607	14
15	Various		2000	9,146		20	457	457	6,212	15
16	Various		2001	48,446		20	2,422	2,422	30,279	16
17	Various		2002	2,252		20	113	113	1,295	17
18	Various		2003	16,990		20	850	850	8,920	18
19	Various		2004	4,707		20	235	235	2,236	19
20	Various		2005	30,220		20	1,511	1,511	12,969	20
21	Various		2006	52,027		20	2,601	2,601	19,510	21
22	Various		2007	5,890		20	295	295	2,012	22
23	Various		2008	23,192		20	2,319	2,319	13,335	23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		675,932	73,521		33,799	(39,722)	185,636	67
68		27,206	698		1,360	662	23,125	68
69			110,732			(110,732)		69
70		\$ 6,790,998	\$ 418,716		\$ 261,636	\$ (157,080)	\$ 3,094,990	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,790,998	\$ 418,716		\$ 261,636	\$ (157,080)	\$ 3,094,990	1
2	Window Unit Air Conditioners	2010	3,368		20	481	481	1,925	2
3	Pvc Accordian Folding Doors	2010	2,904		20	581	581	2,323	3
4	Pvc Accordian Folding Doors	2010	3,564		20	713	713	2,851	4
5	Door Frames	2010	2,960		20	148	148	555	5
6	Resident Room Signage	2010	2,996		20	599	599	2,097	6
7	Awnings	2010	2,354		20	471	471	1,609	7
8	Circuit Extension	2010	8,500		20	850	850	2,692	8
9	Airway Clearance Device	2011	15,800		20	3,160	3,160	9,480	9
10	Air Pulse Generator System	2011	4,400		20	880	880	2,493	10
11	Thru Wall A/C	2011	7,503		20	1,501	1,501	3,752	11
12	Roof Top Unit	2011	5,000		20	250	250	625	12
13	Roof Top Unit	2011	4,893		20	245	245	591	13
14	Water Heater	2012	6,595		20	330	330	495	14
15	Thru Wall A/C Unit	2012	2,695		20	385	385	578	15
16	Video Monitor System	2012	16,353		20	3,271	3,271	5,451	16
17	Vinyl Flooring, Cove Base - Pt Room	2012	10,579		20	2,116	2,116	2,645	17
18	Menards - Sink, Faucet, Granite - Therapy Room - 100 Wing	2012	2,657		20	531	531	709	18
19	Walls, Flooring, Millwork, Handrails-Lobby,Activity,Concierge,Nu	2012	2,500		20	125	125	156	19
20	Repair Sewer Line	2012	4,314		20	158	158	211	20
21	Sealcoating	2012	6,000		20	300	300	375	21
22	Replace 2 Sets Of Doors - Facility Entry - Front Of Building	2012	5,372		20	269	269	291	22
23	Fluorescent Sign Display	2013	7,528		20	376	376	376	23
24	Electric Wiring/Breakers/Directional Boring	2013	4,305		20	144	144	144	24
25	Water Heater	2013	11,620		20	48	48	48	25
26	Duplex Outlets And Hallway Light Rework	2013	3,350		20	70	70	70	26
27	Roof Wall Area Repair	2013	2,926		20	73	73	73	27
28	Removable Signage	2013	3,843		20	705	705	705	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,945,876	\$ 418,716		\$ 280,414	\$ (138,302)	\$ 3,138,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Fire Protection Line	2009	15,714		20	786	786	4,016	9
10	Flooring - Econocare	2009	18,657		20	933	933	12,438	10
11	Windows	2009	96,772		20	4,839	4,839	34,677	11
12	Tile Work	2009	4,000		20	200	200	1,467	12
13	Blacktop	2009	30,000		20	1,500	1,500	7,833	13
14	Masonrv	2009	17,860		20	893	893	3,572	14
15	Fire Protection	2010	105,000		20	5,250	5,250	35,000	15
16	Wallcovering, ceramic tile, carpet, laminate nurses station	2010	84,876		20	4,244	4,244	52,340	16
17	ALTA Survey (Engineer)	2010	2,659		20	133	133	886	17
18	Window Treatments	2010	6,379		20	319	319	2,126	18
19	Installation of Shingles	2010	16,650		20	833	833	3,331	19
20	Circuit Extension	2011	8,500		20	425	425	2,125	20
21	Walls, ceiling tile, flooring, millwork, lighting, cabinetry, handrails, wi	2012	248,972		20	12,449	12,449	24,898	21
22	Carpet Tile	2013	6,409		20	320	320	320	22
23	Oak Cabinets	2013	6,210		20	311	311	311	23
24	Decorative Cornices	2013	2,859		20	143	143	143	24
25	Ceramic Floor Tiles	2013	4,415		20	221	221	153	25
26	Depreciation			73,521			(73,521)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 675,932	\$ 73,521		\$ 33,799	\$ (39,722)	\$ 185,636	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Certified Health Management	1997	27,206	698	20	1,360	662	23,125	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 27,206	\$ 698		\$ 1,360	\$ 662	\$ 23,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 373,602	\$	\$ 46,753	\$ 46,753	10	\$ 206,041	71
72	Current Year Purchases	142,660	1,555	16,511	14,956	10	16,511	72
73	Fully Depreciated Assets	545,928		79	79	10	545,927	73
74								74
75	TOTALS	\$ 1,062,190	\$ 1,555	\$ 63,343	\$ 61,788		\$ 768,479	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VEHICLES	1996	\$ 5,840	\$	\$	\$	5	\$ 5,840	76
77		VEHICLE	2000	13,900				5	13,900	77
78		VEHICLE	2003	18,859				5	18,859	78
79		Used Van- BLDG Co	2009	26,648	4,440	5,329	889	5	25,318	79
80	TOTALS			\$ 65,247	\$ 4,440	\$ 5,329	\$ 889		\$ 63,917	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)	\$ 8,364,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 424,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 349,086	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (75,625)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,970,703	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				2,765			5
6	Allocated from Certified Health Management				10,395			6
7	TOTAL				\$ 13,160			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,720

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Certified Health Management		\$	\$ 7,944	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,944	21

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	209,003	\$		\$	209,003	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				24,917				24,917	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				183,467				183,467	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					125,420			125,420	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): See Supplemental							393,531			393,531	13
14	TOTAL			\$		\$	417,387	\$	518,951	\$	936,338	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,036	\$ 134,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,703,120	1,703,120	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,196	105,196	6
7	Other Prepaid Expenses	639	53,637	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	7,126	7,126	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,829,117	\$ 2,003,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		291,000	13
14	Buildings, at Historical Cost		5,772,152	14
15	Leasehold Improvements, at Historical Cost	430,184	1,132,160	15
16	Equipment, at Historical Cost	663,638	1,115,347	16
17	Accumulated Depreciation (book methods)	(769,761)	(4,043,451)	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>See Attached Schedule</u>	342,487	557,601	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 666,548	\$ 4,824,809	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,495,665	\$ 6,828,331	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 747,280	\$ 859,130	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	334,473	509,476	29
30	Accrued Salaries Payable	190,077	190,077	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,046	11,046	31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,916	32
33	Accrued Interest Payable	2,387	2,387	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	151,715	151,715	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,436,978	\$ 1,786,747	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,609,515	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	559,542	1,592,583	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 559,542	\$ 14,202,098	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,996,520	\$ 15,988,845	46
47	TOTAL EQUITY (page 18, line 24)	\$ 499,145	\$ (9,160,514)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,495,665	\$ 6,828,331	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,850,121	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,850,121	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,350,976)	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)	\$ (1,350,976)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 499,145	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,605,999	1
2	Discounts and Allowances for all Levels	550,810	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,156,809	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	69,991	6
7	Oxygen	16,755	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 86,746	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	23	19
20	Radiology and X-Ray	70	20
21	Other Medical Services	71,295	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 71,388	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	33,226	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,226	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,348,169	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,010,667	31
32	Health Care	3,098,277	32
33	General Administration	3,276,548	33
B. Capital Expense			
34	Ownership	976,649	34
C. Ancillary Expense			
35	Special Cost Centers	988,929	35
36	Provider Participation Fee	348,075	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,699,145	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,350,976)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,350,976)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,770,097	44
45	Private Pay - Net Inpatient Revenue	322,727	45
46	Medicare - Net Inpatient Revenue	1,441,227	46
47	Other-(specify) <u>Managed Care Hospice</u>	446,988	47
48	Other-(specify) <u>Exceptional Care, Pediatric</u>	4,175,770	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,156,809	49

* This must agree with page 4, line 45, column 4.
 ** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
 *** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
 ****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,904	1,887	\$ 78,470	\$ 41.58	1
2	Assistant Director of Nursing	2,000	1,983	59,193	29.85	2
3	Registered Nurses	26,398	26,241	669,433	25.51	3
4	Licensed Practical Nurses	27,998	27,337	635,196	23.24	4
5	CNAs & Orderlies	108,186	105,675	1,264,947	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	909	909	14,511	15.96	8
9	Activity Director	1,996	1,979	28,442	14.37	9
10	Activity Assistants	3,461	3,498	54,903	15.70	10
11	Social Service Workers	1,960	1,943	31,034	15.97	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,015	39,394	19.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,569	7,540	77,516	10.28	15
16	Dishwashers	5,140	4,957	44,048	8.89	16
17	Maintenance Workers	3,615	3,532	76,804	21.75	17
18	Housekeepers	16,060	15,954	178,951	11.22	18
19	Laundry	7,229	7,052	74,163	10.52	19
20	Administrator	1,904	1,887	99,285	52.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	1,983	44,266	22.32	23
24	Clerical	3,428	3,374	46,816	13.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,944	1,927	49,664	25.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,479	3,404	37,629	11.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,080	2,063	52,591	25.49	33
34	TOTAL (lines 1 - 33)	231,292	227,140	\$ 3,657,256 *	\$ 16.10	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	347	\$ 17,445	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	42	1,892	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	125	8,079	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	40	2,311	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	100	3,868	12-03	45
46	Other(specify)				46
47	Psychosocial Consultant	15	625	12-03	47
48					48
49	TOTAL (lines 35 - 48)	669	\$ 40,220		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Martha Jones	Administrator	0	\$ 99,285	Workers' Compensation Insurance	\$ 123,619	IDPH License Fee	\$		
				Unemployment Compensation Insurance	44,747	Advertising: Employee Recruitment			
				FICA Taxes	275,757	Health Care Worker Background Check			
				Employee Health Insurance	92,472	(Indicate # of checks performed 93)	930		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Employee Hiring Costs	6,062		
				Pension Plan	7,201	Dues & Subscriptions			
				Employee Benefits	206	Licenses and Permits	3,508		
						Alloc. Certified Health Management	418		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 99,285			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other									
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Certified Health Management-Management Fees			\$ 73,380	\$ 544,002			\$ 10,918		
Certified Health Management-Administrative Consultants			21,708						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 95,088	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Description		
C. Professional Services				Line #			Amount		
Vendor/Payee	Type	Amount	Description			Amount			
Certified Health Management	Bookkeeping	\$ 276,000				\$			
Paychex	Payroll	11,494				Out-of-State Travel			
FR&R	Accounting	7,359							
Richard Peelo	Accounting	3,750				In-State Travel			
Ehealth Solutions	MDS Software	3,894							
Personnel Planners	Unemployment Consulting	2,434				Seminar Expense			
Corcoran Ender	401k Consulting	1,110				New Focus			
Adj on 5A	Legal	5,720				Alloc. Certified Health Management			
						2,016			
						Entertainment Expense			
						()			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 311,761	\$			TOTAL		
							\$ 12,388		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/13

Ending:

12/31/13

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,690 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 348,075
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT