

Facility Name & ID Number Renaissance at Midway

0041749 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	249	Skilled (SNF)	249	90,885	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	90,885	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			12,507	12,507	8
9	SNF/PED					9
10	ICF	55,611	2,166	8,559	66,336	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,611	2,166	21,066	78,843	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

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 06/05/2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/05/2000 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 249 and days of care provided 7,990

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

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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	375,109	111,836	46,210	533,155		533,155	533,155			1
2	Food Purchase		413,422		413,422	(29,565)	383,857	(114)	383,743		2
3	Housekeeping	269,409	56,659		326,068		326,068		326,068		3
4	Laundry	122,422	34,071		156,493		156,493		156,493		4
5	Heat and Other Utilities			274,360	274,360		274,360	(7,840)	266,520		5
6	Maintenance	95,853	78,747	202,289	376,889		376,889	39,837	416,726		6
7	Other (specify):*							470	470		7
8	TOTAL General Services	862,793	694,735	522,859	2,080,387	(29,565)	2,050,822	32,352	2,083,174		8
	B. Health Care and Programs										
9	Medical Director			15,900	15,900		15,900		15,900		9
10	Nursing and Medical Records	4,891,547	877,788	19,588	5,788,923		5,788,923	555	5,789,478		10
10a	Therapy	152,724			152,724		152,724		152,724		10a
11	Activities	374,024	27,391	1,760	403,175		403,175		403,175		11
12	Social Services	163,060			163,060		163,060		163,060		12
13	CNA Training										13
14	Program Transportation			2,401	2,401		2,401		2,401		14
15	Other (specify):*							1,958	1,958		15
16	TOTAL Health Care and Programs	5,581,355	905,179	39,649	6,526,183		6,526,183	2,512	6,528,695		16
	C. General Administration										
17	Administrative	223,871		1,146,826	1,370,697		1,370,697	(1,102,234)	268,463		17
18	Directors Fees										18
19	Professional Services			228,253	228,253	(3,455)	224,798	(31,734)	193,064		19
20	Dues, Fees, Subscriptions & Promotions			107,334	107,334		107,334	(58,943)	48,391		20
21	Clerical & General Office Expenses	302,897	59,204	717,453	1,079,554		1,079,554	(400,951)	678,603		21
22	Employee Benefits & Payroll Taxes			1,485,912	1,485,912	29,565	1,515,477		1,515,477		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,973	19,973		19,973	646	20,619		24
25	Other Admin. Staff Transportation			1,535	1,535		1,535	6,534	8,069		25
26	Insurance-Prop.Liab.Malpractice			1,390,378	1,390,378		1,390,378	(119,996)	1,270,382		26
27	Other (specify):*							24,478	24,478		27
28	TOTAL General Administration	526,768	59,204	5,097,664	5,683,636	26,110	5,709,746	(1,682,201)	4,027,545		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,970,916	1,659,118	5,660,172	14,290,206	(3,455)	14,286,751	(1,647,336)	12,639,415		29

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

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

V. COST CENTER EXPENSES (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			147,872	147,872		147,872	318,943	466,815			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,764	155,764		155,764	254,730	410,494			32
33	Real Estate Taxes					3,455	3,455	474,387	477,842			33
34	Rent-Facility & Grounds			2,074,457	2,074,457		2,074,457	(2,073,960)	497			34
35	Rent-Equipment & Vehicles			53,333	53,333		53,333	3,061	56,394			35
36	Other (specify):*							46,207	46,207			36
37	TOTAL Ownership			2,431,426	2,431,426	3,455	2,434,881	(976,631)	1,458,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		636,967	1,694,621	2,331,588		2,331,588	(31,198)	2,300,390			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			558,739	558,739		558,739		558,739			42
43	Other (specify):*	114,176		7,458	121,634		121,634	(121,634)	(0)			43
44	TOTAL Special Cost Centers	114,176	636,967	2,260,818	3,011,961		3,011,961	(152,832)	2,859,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,085,092	2,296,085	10,352,416	19,733,593	(0)	19,733,593	(2,776,799)	16,956,794			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

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0041749

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	(11,110)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,136)	30		9
10	Interest and Other Investment Income	(7,422)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(114)	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	(13,494)	21		18
19	Entertainment	(1,027)	21		19
20	Contributions	(19,229)	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	(502,220)	21		24
25	Fund Raising, Advertising and Promotional	(36,319)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(814)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(506,797)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,130,682)		\$	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)	(1,646,117)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,646,117)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,776,799)		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

BHF USE ONLY						
48		49		50		51
						52

Renaissance at Midway

	ID#	0041749
Report Period Beginning:		01/01/14
Ending:		12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Building Company - Additional R&M	\$ 4,430	06	1
2	Medical Records	(709)	10	2
3	Jury Duty Income	(17)	10	3
4	Patient Needs	(17,722)	10	4
5	Patient Clothing	(2,296)	10	5
6	Bank Charges	(18,895)	21	6
7	Sequestration	(100,041)	21	7
8	Prior Year Insurance	(134,301)	26	8
9	Community Relations Salary	(16,751)	43	9
10	Web Site	(446)	21	10
11	Collections	(24,086)	21	11
12	COPE Dues	(4,803)	20	12
13	Annual Report	(279)	20	13
14	Out of State Seminars	(798)	24	14
15	Building Company - Fees	(100)	21	15
16	Building Company - Accounting Fees	(9,500)	19	16
17	Building Company - Legal Fees	(330)	19	17
18	Building Company - Amortization	(4,194)	36	18
19	Non-Allowable Legal	(42,281)	19	19
20	Marketing Salaries	(97,425)	43	20
21	Non-Allowable Interest	(5,417)	32	21
22	Additional R&M	12,656	06	22
23	Capitalized R&M	(8,548)	06	23
24	Gain on Disposal of Assets	(27,487)	30	24
25	Non-Allowable Expense	(7,458)	43	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		(506,797)	49

Renaissance at Midway

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Report Period Beginning: 01/01/14

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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 at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	(114)											(114)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,110)		3,270									(7,840)	5
6	Maintenance	8,538	15,847	15,452									39,837	6
7	Other (specify):*			470									470	7
8	TOTAL General Services	(2,686)	15,847	19,191									32,352	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,745)		22,100					(801)				555	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,958									1,958	15
16	TOTAL Health Care and Programs	(20,745)		24,058					(801)				2,512	16
	C. General Administration													
17	Administrative			(1,114,734)				12,500					(1,102,234)	17
18	Directors Fees													18
19	Professional Services	(52,111)	9,830	9,922				625					(31,734)	19
20	Fees, Subscriptions & Promotions	(60,630)		1,687									(58,943)	20
21	Clerical & General Office Expenses	(661,122)	100	255,717				4,354					(400,951)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(798)		1,444									646	24
25	Other Admin. Staff Transportation			6,534									6,534	25
26	Insurance-Prop.Liab.Malpractice	(134,301)	13,560	745									(119,996)	26
27	Other (specify):*			22,989				1,489					24,478	27
28	TOTAL General Administration	(908,962)	23,490	(815,697)				18,968					(1,682,201)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(932,392)	39,337	(772,448)				18,968	(801)				(1,647,336)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14 Ending:

12/31/14

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	(59,623)	367,550	11,016									318,943	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,839)	264,904	2,664									254,730	32
33	Real Estate Taxes		469,998	4,389									474,387	33
34	Rent-Facility & Grounds		(2,074,458)	498									(2,073,960)	34
35	Rent-Equipment & Vehicles			3,061									3,061	35
36	Other (specify):*	(4,194)	50,401										46,207	36
37	TOTAL Ownership	(76,655)	(921,605)	21,629									(976,631)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(21,152)	(8,095)		(1,951)				(31,198)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(121,634)											(121,634)	43
44	TOTAL Special Cost Centers	(121,634)				(21,152)	(8,095)		(1,951)				(152,832)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,130,682)	(882,268)	(750,818)		(21,152)	(8,095)	18,968	(2,752)				(2,776,799)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 2,074,458	Claridge at Cicero LP		\$	\$ (2,074,458)	1
2	V	32 Interest	669	Claridge at Cicero LP		265,573	264,904	2
3	V	06 Repairs and Maintenance		Claridge at Cicero LP		1,899	1,899	3
4	V	06 Linen Replacement		Claridge at Cicero LP		13,948	13,948	4
5	V	36 MIP Expense		Claridge at Cicero LP		46,207	46,207	5
6	V	26 Insurance		Claridge at Cicero LP		13,560	13,560	6
7	V	21 Fees		Claridge at Cicero LP		100	100	7
8	V	19 Accounting		Claridge at Cicero LP		9,500	9,500	8
9	V	19 Legal		Claridge at Cicero LP		330	330	9
10	V	33 Real Estate Taxes		Claridge at Cicero LP		469,998	469,998	10
11	V	30 Depreciation		Claridge at Cicero LP		367,550	367,550	11
12	V	36 Amortization		Claridge at Cicero LP		4,194	4,194	12
13	V							13
14	Total		\$ 2,075,127			\$ 1,192,859	\$ * (882,268)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 3,270	\$ 3,270
16	V	6 MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	5,300	5,300
17	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	10,151	10,151
18	V	7 EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	470	470
19	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	22,100	22,100
20	V	15 EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,958	1,958
21	V	17 ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	32,093	32,093
22	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	9,922	9,922
23	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,687	1,687
24	V	21 CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	215,403	215,403
25	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	40,313	40,313
26	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,444	1,444
27	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	6,534	6,534
28	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	745	745
29	V	27 EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	22,989	22,989
30	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	11,016	11,016
31	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,664	2,664
32	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	4,389	4,389
33	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	498	498
34	V	35 AUTO LEASE		NUCARE SERVICES CORP.	100.00%	3,061	3,061
35	V						
36	V	17 BOOKKEEPING FEES	1,146,826	NUCARE SERVICES CORP.	100.00%		(1,146,826)
37	V						
38	V						
39	Total		\$ 1,146,826			\$ 396,008	\$ * (750,818)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workers Compensation	\$ 149,969	MAPLE LEAF		\$ 149,969	\$	15
16	V	26 Liability Insurance	529,765	MAPLE LEAF		529,765		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		\$ 679,734			\$ 679,734	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 DME & MEDICAL SUPPLIES	\$ 229,055	INTEGRA HEALTHCARE EQUIPMENT		\$ 207,903	\$ (21,152)
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		\$ 229,055			\$ 207,903	\$ * (21,152)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 RESPIRATORY SERVICES	\$ 38,835	INTEGRA RESPIRATORY SERVICES LLC		\$ 30,740	\$ (8,095)
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		\$ 38,835			\$ 30,740	\$ * (8,095)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR FINANCIAL SERVICES CORP.	100.00%	\$ 12,500	\$	12,500	15
16	V	19 PROFESSIONAL FEES		JLR FINANCIAL SERVICES CORP.	100.00%	625		625	16
17	V	21 OFFICE		JLR FINANCIAL SERVICES CORP.	100.00%	4,354		4,354	17
18	V	27 EMPLOYEE BENEFITS		JLR FINANCIAL SERVICES CORP.	100.00%	1,489		1,489	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		\$			\$ 18,968	\$ *	18,968	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 AMBULANCE SERVICES	\$ 3,453	LIFELINE AMBULANCE		\$ 2,652	\$ (801)
16	V	39 AMBULANCE SERVICES	8,402	LIFELINE AMBULANCE		6,451	(1,951)
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		\$ 11,855			\$ 9,103	\$ * (2,752)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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.

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	ABRAHAM STERN	4.900%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REI	CHICAGO	CLARIDGE AT CICERO	CHICAGO	BUILDING CO.	1
2	EVAN MICHAEL STERN 2005 TRUST	0.900%	CALIFORNIA GARDENS CORP.	CHICAGO	JLR FINANCIAL SERVICES CO	LINCOLNWOOD	FINANCIAL SVCS.	2
3	JONATHAN BRYAN STERN 2001 TRUST	0.900%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	MARSHALL MAUER	6.250%	CLARIDGE IMPERIAL, LTD.	CHICAGO	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	4
5	MAURICE AARON	4.250%	JACKSON CORP.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	5
6	ORIOLE TRUST	4.950%	MONROE CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	6
7	ORA AARON	2.000%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	7
8	RAJCHENBACH FAMILY TRUST	25.000%	ARIA POST ACUTE CARE	HILLSIDE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	8
9	ROBERT HARTMAN FAMILY TRUST	20.050%	THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10	SUSAN STERN	4.900%	RENAISSANCE EAST	MESA, ARIZONA	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	10
11	TODD ANDREW STERN 2001 TRUST	0.900%	RENAISSANCE PARK SOUTH, LLC	CHICAGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV	11
12	MARK HOLLANDER DISCRETIONARY TRUST	8.333%	RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13	SHARON HOLLANDER DISCRETIONARY TRUST	8.333%	RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14	FEIGE C. KNOBEL DISCRETIONARY TRUST	8.334%	RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT - HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				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

Facility Name & ID Number

Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

Facility Name & ID Number Renaissance at Midway # 0041749 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Jack Rajchenbach	Relative	Administrative		See Attached	6.00	10.00%	Alloc. Sal.	\$ 12,500	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	\$ 12,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 NUCARE SERVICES CORP.
 Street Address 7257 N. LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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	AVAIL. CENSUS DAYS 1,239,904	17	\$ 44,608	\$	90,885	\$ 3,270	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	72,310	72,310	90,885	5,300	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 1,239,904	17	138,492		90,885	10,151	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS 1,239,904	17	6,405		90,885	470	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	301,506	301,506	90,885	22,100	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS 1,239,904	17	26,708		90,885	1,958	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS 1,239,904	17	437,828	437,828	90,885	32,093	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,239,904	17	135,365		90,885	9,922	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 1,239,904	17	23,010		90,885	1,687	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS 1,239,904	17	2,938,655	2,938,655	90,885	215,403	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 1,239,904	17	549,976		90,885	40,313	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 1,239,904	17	19,695		90,885	1,444	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 1,239,904	17	89,139		90,885	6,534	13
14	26	INSURANCE	AVAIL. CENSUS DAYS 1,239,904	17	10,164		90,885	745	14
15	27	EMPLOYEE BENEFITS - ADM	AVAIL. CENSUS DAYS 1,239,904	17	313,624		90,885	22,989	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,239,904	17	150,292		90,885	11,016	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 1,239,904	17	36,349		90,885	2,664	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 1,239,904	17	59,877		90,885	4,389	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 1,239,904	17	6,796		90,885	498	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS 1,239,904	17	41,766		90,885	3,061	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,402,565	\$ 3,750,299		\$ 396,008	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Maple Leaf Insurance
 Street Address PO Box 69,720 West Bay Rd.
 City / State / Zip Code Grand Cayman KY1-1102
 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	22	Workers Compensation	Direct Allocation		\$	\$		\$ 149,969	1
2	26	Liability Insurance	Direct Allocation					529,765	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				\$	\$		\$ 679,734	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Integra Healthcare Equipment, LLC

Street Address

747 Church Road

City / State / Zip Code

Elmhurst, IL 60126

Phone Number

(630) 834-3700

Fax Number

(630) 834-1500

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	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 207,903	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				\$	\$		\$ 207,903	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Integra Respiratory Services LLC
 Street Address 747 Church Road
 City / State / Zip Code Elmhurst, IL 60126
 Phone Number (630) 834-3700
 Fax Number (630) 834-1500

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	39	RESPIRATORY SERVICES	DIRECT ALLOCATION		\$	\$		\$ 30,740	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				\$	\$		\$ 30,740	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 JLR FINANCIAL SERVICES CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

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	
17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	48	9	\$ 100,000	\$ 100,000	6	\$ 12,500	1
19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	9	5,000		6	625	2
21	OFFICE	AVG. HOURS WORKED	48	9	34,828	34,828	6	4,354	3
27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	48	9	11,911		6	1,489	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				\$ 151,739	\$ 134,828		\$ 18,968	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 Lifeline Ambulance LLC
 Street Address 2424 S. Wabash Avenue
 City / State / Zip Code Chicago, IL 60616
 Phone Number (312) 949-9595
 Fax Number (312) 949-9262

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	10	AMBULANCE	DIRECT ALLOCATION		\$	\$		\$ 2,652	1
2	39	AMBULANCE	DIRECT ALLOCATION					6,451	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				\$	\$		\$ 9,103	25

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending: 12/31/14

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

Facility Name & ID Number

Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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						
		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	HUD		X	Mortgage			\$	\$ 9,257,629			\$ 265,573						
2																	
3																	
4																	
5																	
Working Capital																	
6	The Private Bank		X	Line of Credit				2,515,314			150,347						
7	Allocated from NuCare Services		X								2,664						
8																	
9	TOTAL Facility Related						\$	\$ 11,772,943			\$ 418,584						
B. Non-Facility Related*																	
10	Interest Income		X								(7,422)						
11	Interest Income - Bldg Co.		X								(669)						
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (8,092)						
15	TOTALS (line 9+line14)						\$	\$ 11,772,943			\$ 410,492						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46,207 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.)

** 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 at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	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 2013 report.		\$	636,211		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.)		\$	544,003		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	(92,208)		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	566,595		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.)		\$	3,455		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.		\$	477,842		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	528,680	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 2013 \$</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 2013 \$	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 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	513,247	9																
	2011	511,112	10																
	2012	614,037	11																
	2013	539,614	12																
2014 Accrual = \$539,614 x 1.05 = \$566,595																			
Allocated from Nuicare Services Corp. \$4,389																			

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance at Midway COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041749

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>19-03-304-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,860.97</u>	\$ <u>1,860.97</u>
2. <u>19-03-304-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,573.14</u>	\$ <u>2,573.14</u>
3. <u>19-03-304-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>8,002.32</u>	\$ <u>8,002.32</u>
4. <u>19-03-304-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>132,185.95</u>	\$ <u>132,185.95</u>
5. <u>19-03-304-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>230,903.70</u>	\$ <u>230,903.70</u>
6. <u>19-03-304-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>154,626.74</u>	\$ <u>154,626.74</u>
7. <u>19-03-304-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>9,461.09</u>	\$ <u>9,461.09</u>
8. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>89,368.57</u>	\$ <u>4,388.98</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>628,982.48</u></u>	\$ <u><u>544,002.89</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? X YES 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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	\$ _____	\$ _____

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 at Midway

0041749 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,903 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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).

None

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	48,972		\$ 155,000	1
2	Allocated from 7257 N. Lincoln			7,858	2
3	TOTALS	48,972		\$ 162,858	3

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	249		2000	\$ 9,032,497	\$ 367,550	35	\$ 260,214	\$ (107,336)	\$ 3,794,788
5									
6									
7									
8									
Improvement Type**									
9	Various		2000	186,297		20	9,284	9,284	134,753
10	Various		2001	47,574		20	2,379	2,379	32,328
11	Various		2002	15,861		20			15,861
12	Various		2003	126,758		20	5,399	5,399	106,857
13	Various		2004	42,166		20	1,654	1,654	37,046
14	Various		2005	29,048		20	2,138	2,138	25,701
15	Various		2006	172,462		20	11,979	11,979	141,037
16	Various		2007	3,200		20	633	633	2,274
17	Various		2009	23,132		20	3,076	3,076	18,492
18	Various		2010	254,899		20	25,094	25,094	110,413
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			568,779		28,427	28,427	168,197	67
68			131,373	5,314	5,087	(227)	46,101	68
69				120,385		(120,385)		69
70			\$ 10,634,046	\$ 493,249		\$ 355,364	\$ (137,885)	\$ 4,633,848 70

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		\$ 10,634,046	\$ 493,249		\$ 355,364	\$ (137,885)	\$ 4,633,848	1
2	1St Floor Rehab Room & Resident Rooms	2011	8,650		20	865	865	3,460	2
3	Furnish/ Install 4Th Flr Cafeteria- 7 Blinds, 1St Flr Cafe-5 Blinds	2011	4,405		20	441	441	1,762	3
4	Hot Tab Risers Installed	2011	5,100		20	510	510	2,040	4
5	1St & 4Th Floor Cafe Blinds	2011	4,700		20	470	470	1,880	5
6	3Rd Floor Resident, Wound Care, Nurse Station, Mds Room & Ha	2011	9,017		20	902	902	3,457	6
7	3Rd Floor Patient Rooms & Bathroom Paint & Skim Coat	2011	10,250		20	1,025	1,025	3,929	7
8	Nurse Station Construction & Installation	2011	8,600		20	860	860	3,225	8
9	Roof Repair, Sealing & Installation Of New Roof	2011	24,000		20	2,400	2,400	9,200	9
10	Tempered Glass Windows	2011	2,611		20	261	261	979	10
11	Pavement Sealcoat	2011	5,700		20	570	570	2,090	11
12	Paint 30 Rooms And Bathrooms On 2Nd Floor, Plaster Holes On V	2011	13,875		20	1,388	1,388	5,088	12
13	1-4 Floor North Stairwell Painting	2011	3,500		20	350	350	1,283	13
14	Doors Security System, Back Up Power Supply	2011	4,908		20	491	491	1,759	14
15	2Nd Floor Resident Room Shades	2011	6,870		20	687	687	2,462	15
16	Landscaping, Trees, Rocks, Hardscape Concrete	2011	4,835		20	322	322	1,182	16
17	Replace Door Closers In 8 Patient Rooms, Furnish 14 Door Holder	2011	17,030		20	1,703	1,703	5,961	17
18	166 Curtains & Draperies	2011	24,490		20	2,449	2,449	8,572	18
19	Labor And Materials For A/C Repair	2011	5,966		20	497	497	1,740	19
20	Replaced Condensor Fan Motor On Chiller	2011	2,500		20	125	125	427	20
21	Replace A/C Chiller	2011	3,351		20	168	168	614	21
22	Fire Sprinkler Work	2011	2,830		20	142	142	519	22
23	Built In Cabinets, Panel, Crown Molding	2011	8,850		20	443	443	1,770	23
24	Wallpaper Removal, Paint & Skim Coat	2011	12,500		20	625	625	2,448	24
25	Paint Hallways	2011	27,000		20	1,350	1,350	5,400	25
26	1St Floor Nurses Station - Countertop & Cabinetry	2011	9,890		20	495	495	1,772	26
27	Kitchenette - Build Wall, 2 Diffuser, 4 Receptacles, Remodel Thera	2011	29,593		20	1,480	1,480	5,179	27
28	Nurse Station - Cabinets And Drawers	2012	4,945		20	989	989	2,885	28
29	Divider Wall	2012	4,310		20	862	862	2,442	29
30	Lighting On Different Floors	2012	3,680		20	368	368	1,043	30
31	Divider Wall	2012	4,310		20	862	862	2,371	31
32	Parking Lot Lighting	2012	3,800		20	253	253	697	32
33	Smoke Detectors	2012	7,925		20	1,132	1,132	2,830	33
34	TOTAL (lines 1 thru 33)		\$ 10,924,037	\$ 493,249		\$ 380,846	\$ (112,403)	\$ 4,724,311	34

**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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 10,924,037	\$ 493,249		\$ 380,846	\$ (112,403)	\$ 4,724,311	1
2	Security Cameras	2012	3,205		20	321	321	828	2
3	Replace Time Delated Egress Maglock	2013	2,560		20	128	128	235	3
4	Replace Bad Time Egress & Cameras	2013	3,200		20	160	160	227	4
5	Install New Vinyl Base In All Residents Rooms With New Tiles	2014	5,500		20	275	275	275	5
6	Shower Room Demolition And Repair - 2Nd & 3Rd Floor	2014	36,600		20	1,525	1,525	1,525	6
7	Install 18 New Window Sills For Dining Room On 1St, 2Nd,	2014							7
8	3Rd And 4Th Floor On Solid Surface	2014	4,500		20	225	225	225	8
9	Remodel 1St Floor Shower Room, Demolish Existing Tiles	2014							9
10	On Floor And Walls, Remove Drywall By Shower	2014	19,200		20	320	320	320	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)		\$ 10,998,802	\$ 493,249		\$ 383,800	\$ (109,449)	\$ 4,727,945	34

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Totals from Page 12C, Carried Forward		\$ 10,998,802	\$ 493,249		\$ 383,800	\$ (109,449)	\$ 4,727,945	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)		\$ 10,998,802	\$ 493,249		\$ 383,800	\$ (109,449)	\$ 4,727,945	34

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 12D, Carried Forward		\$ 10,998,802	\$ 493,249		\$ 383,800	\$ (109,449)	\$ 4,727,945	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)		\$ 10,998,802	\$ 493,249		\$ 383,800	\$ (109,449)	\$ 4,727,945	34

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2005	45,177		20	2,259	2,259	22,589	9
10	Repair Door Closures	2006	5,062		20	253	253	2,024	10
11	Repair Door Holders	2006	7,201		20	360	360	2,880	11
12	Tv Lounge/Stairway	2007	5,000		20	250	250	2,000	12
13	Flooring 4Th Floor Corridor	2007	41,150		20	2,058	2,058	16,462	13
14	Install - Card Swipe And Door Strike	2007	3,501		20	175	175	1,400	14
15	2 Tormax Ttx Ii Low Ennergy Operator	2007	3,470		20	174	174	1,390	15
16	10 Fantagraph Pleated Shades, Window Fashions	2007	5,394		20	270	270	2,158	16
17	Fire Sprinkler Work	2007	4,929		20	246	246	1,970	17
18	Admission/Hallway Lobby/Reception Area	2007	6,560		20	328	328	2,624	18
19	6 Track System For Cubicle Curtain	2007	3,310		20	166	166	1,326	19
20	1St Floor 22 Resident Washrooms	2007	4,620		20	231	231	1,848	20
21	14 Pleated Shades/Blinds Window Fashion	2007	8,154		20	408	408	3,262	21
22	1 Tormax Ttx Ii Low Ennergy Operator	2007	4,968		20	248	248	1,986	22
23	Door Closer/ Holders	2007	4,045		20	202	202	1,618	23
24	Generator Upgrade	2007	5,793		20	290	290	2,318	24
25	Flooring 22 Residents Washrooms	2007	4,920		20	246	246	1,968	25
26	Flooring Admission Hallway/Lobby/Reception Area	2007	6,560		20	328	328	2,624	26
27	1St Floor Reface 34 Doors	2007	2,295		20	115	115	920	27
28	1St Floor Reface 34 Doors	2007	2,295		20	115	115	920	28
29	Door Locks	2007	2,832		20	142	142	1,134	29
30	Construct Patient Room	2007	5,000		20	250	250	2,000	30
31	Ventilation Work For Generator	2007	26,978		20	1,349	1,349	10,792	31
32	Window Coverings	2007	23,163		20	1,158	1,158	9,264	32
33	Construct Closets	2007	6,000		20	300	300	2,400	33
34	TOTAL (lines 1 thru 33)		\$ 238,377	\$		\$ 11,921	\$ 11,921	\$ 99,877	34

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 12F, Carried Forward		\$ 238,377	\$		\$ 11,921	\$ 11,921	\$ 99,877	1
2	Flooring	2007	3,890		20	195	195	1,558	2
3	Drapery	2007	5,169		20	258	258	2,066	3
4	Painted 33 Rooms; Holes Patching & Repairing	2008	6,930		20	347	347	2,716	4
5	Armstrong Wide Material - Connection Corlon Stone Harbor - Flooring	2008	4,471		20	224	224	1,753	5
6	Replaced Door Closures & Holders For Rooms	2008	10,865		20	543	543	4,346	6
7	Reface Doors & Metal Door Kickplates	2008	8,050		20	403	403	3,222	7
8	Routing And Cracksealing Of Parking Lot; Concrete Removal & Repla	2008	6,909		20	345	345	2,301	8
9	Sign Lightbox And Banner	2008	5,726		20	286	286	1,812	9
10	Landscape Irrigation System	2008	6,500		20	325	325	1,950	10
11	Painting Walls in 31 Rooms	2009	8,725		20	436	436	2,618	11
12	Landscape retaining Walls, Plants, Perennials, and Mulch	2009	9,000		20	450	450	2,700	12
13	Chair Rail - Oak Color	2009	4,410		20	221	221	1,324	13
14	2nd and 3rd Flr Dining Rm- Tiles, Window Treatments, Chair Rails	2009	59,648		20	2,968	2,968	17,808	14
15	Outside Security System - Monitors, Strobe Lights, Indoor and Outdoo	2009	21,603		20	1,080	1,080	6,480	15
16	Painting 30 Rooms	2009	12,305		20	615	615	3,692	16
17	Landscaping, Rocks, Boulders, Plants, and Mulch	2009	9,000		20	450	450	2,700	17
18	Chair Rails for 3rd Floor	2009	2,482		20	124	124	744	18
19	5 Indoor Cameras; 1 Outdoor Camera; 6 Boxes of Wire	2009	3,465		20	173	173	1,040	19
20	Wifi Cable Wiring	2013	5,500		20	275	275	550	20
21	Solid-State Starter	2013	3,047		20	152	152	304	21
22	1 Crv Heat Exchanger Cb 1796 Ch1801H	2013	4,910		20	246	246	246	22
23	Sand down and satin 250 doors, laminate and reinstalled doors	2014	22,500		20	1,125	1,125	1,125	23
24	Removed and installed floor tiling-resident rooms on 1,2,3 & 4th FL	2014	62,000		20	3,100	3,100	3,100	24
25	1st, 2nd, 3rd, and 4th Floor Dining Room - Wallcoverings	2014	38,297		20	1,915	1,915	1,915	25
26	8 Fire doors	2014	5,000		20	250	250	250	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 568,779	\$		\$ 28,427	\$ 28,427	\$ 168,197	34

**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	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue	2004	70,720	1,813	20	2,021	208	22,479	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from NuCare Services Corp	2003	859	56	20	43	(13)	477	9
10	Allocated from NuCare Services Corp	2004	17,431	1,141	20	873	(268)	9,347	10
11	Allocated from NuCare Services Corp	2005	1,033	68	20	52	(16)	509	11
12	Allocated from NuCare Services Corp	2006	1,401	92	20	70	(22)	586	12
13	Allocated from NuCare Services Corp	2008	1,477	97	20	74	(23)	462	13
14	Allocated from NuCare Services Corp	2009	23,780	1,556	20	1,189	(367)	6,670	14
15	Allocated from NuCare Services Corp	2010	3,654	239	20	183	(56)	824	15
16	Allocated from NuCare Services Corp	2011	197	13	20	10	(3)	39	16
17	Allocated from NuCare Services Corp	2012	220	14	20	11	(3)	30	17
18	Allocated from NuCare Services Corp	2014	2,749	180	20	83	(97)	83	18
19									19
20	Allocated from 7257 N. Lincoln Avenue	2005	6,447	45	20	408	363	3,857	20
21	Allocated from 7257 N. Lincoln Avenue	2004	1,405		20	70	70	738	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)		\$ 131,373	\$ 5,314		\$ 5,087	\$ (227)	\$ 46,101	34

**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		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 12H, Carried Forward		\$ 131,373	\$ 5,314		\$ 5,087	\$ (227)	\$ 46,101	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)		\$ 131,373	\$ 5,314		\$ 5,087	\$ (227)	\$ 46,101	34

**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	\$ 841,904	\$ 4,946	\$ 76,100	\$ 71,154	10	\$ 543,305	71
72	Current Year Purchases	67,545	713	6,703	5,990	10	6,703	72
73	Fully Depreciated Assets	533,877		83	83	10	533,875	73
74								74
75	TOTALS	\$ 1,443,326	\$ 5,659	\$ 82,885	\$ 77,226		\$ 1,083,882	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		Allocated from NuCare Services C	2014	\$ 649	\$ 43	\$ 130	\$ 87	5	\$ 574	76
77										77
78										78
79										79
80	TOTALS			\$ 649	\$ 43	\$ 130	\$ 87		\$ 574	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)	\$ 12,605,635	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 498,951	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 466,815	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,136)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,812,401	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	<u>Allocated from NuCare Services Corp</u>				<u>498</u>			5
6								6
7	TOTAL				\$ 498			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 47,705 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	<u>Facility</u>	<u>2013 Honda Accord</u>	\$ <u>469.00</u>	\$ <u>5,628</u>	17
18	<u>Allocated from NuCare Services Corp</u>			<u>3,061</u>	18
19					19
20					20
21	TOTAL		\$ 469.00	\$ 8,689	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.

Facility Name & ID Number Renaissance at Midway # 0041749 Report Period Beginning: 01/01/14 Ending: 12/31/14
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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	3 Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 702,579	\$		\$ 702,579	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			229,677			229,677	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			688,878			688,878	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				485,241		485,241	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					73,487	151,726		225,213	13
14	TOTAL			\$		\$ 1,694,621	\$ 636,967		\$ 2,331,588	14

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

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 8,723	\$ 334,780	1
2	Cash-Patient Deposits	14,690	14,690	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,759,426	7,273,523	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,904	20,856	6
7	Other Prepaid Expenses	8,644	8,644	7
8	Accounts Receivable (owners or related parties)	1,000	1,000	8
9	Other(specify):	18,271	1,193,478	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,813,658	\$ 8,846,971	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		209,865	13
14	Buildings, at Historical Cost		8,016,178	14
15	Leasehold Improvements, at Historical Cost	1,259,612	1,900,975	15
16	Equipment, at Historical Cost	1,179,045	2,540,871	16
17	Accumulated Depreciation (book methods)	(1,823,114)	(6,357,064)	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):	936,473	1,880,704	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,552,016	\$ 8,191,529	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,365,674	\$ 17,038,500	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,930,134	\$ 3,930,133	26
27	Officer's Accounts Payable	15,385	15,385	27
28	Accounts Payable-Patient Deposits	3,383	3,383	28
29	Short-Term Notes Payable	2,515,314	2,650,952	29
30	Accrued Salaries Payable	508,113	508,113	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,821	60,821	31
32	Accrued Real Estate Taxes(Sch.IX-B)		566,595	32
33	Accrued Interest Payable		21,987	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,033,150	\$ 7,757,369	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,121,991	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	213,646	213,646	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 213,646	\$ 9,335,637	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,246,796	\$ 17,093,006	46
47	TOTAL EQUITY(page 18, line 24)	\$ 118,878	\$ (54,506)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,365,674	\$ 17,038,500	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 886,612	1
2	Restatements (describe):		2
3	Prior Period Worker Compensation	45,426	3
4	Rounding	5	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 932,043	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(813,165)	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)	\$ (813,165)	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)	\$ 118,878	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 14,883,690	1	
2	Discounts and Allowances for all Levels	(2,569,361)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,314,329	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	4,704,410	6	
7	Oxygen	16,702	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,721,112	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	1,342,121	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	325,636	19	
20	Radiology and X-Ray	53,979	20	
21	Other Medical Services	127,616	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,849,352	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	7,422	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,422	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	See Supplemental Schedule	28,213	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,213	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,920,428	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	2,080,387	31	
32	Health Care	6,526,183	32	
33	General Administration	5,683,636	33	
B. Capital Expense				
34	Ownership	2,431,426	34	
C. Ancillary Expense				
35	Special Cost Centers	2,453,222	35	
36	Provider Participation Fee	558,739	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,733,593	40	
41	Income before Income Taxes (line 30 minus line 40)**	(813,165)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (813,165)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 9,115,469	44
45	Private Pay - Net Inpatient Revenue	343,264	45
46	Medicare - Net Inpatient Revenue	1,008,130	46
47	Other-(specify) CCHHS	595,302	47
48	Other-(specify) Managed Care	1,252,164	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,314,329	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.

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	2,035	2,094	\$ 116,889	\$ 55.82	1
2	Assistant Director of Nursing	1,978	2,105	88,884	42.23	2
3	Registered Nurses	40,686	44,842	1,514,325	33.77	3
4	Licensed Practical Nurses	50,753	55,435	1,546,628	27.90	4
5	CNAs & Orderlies	128,895	140,677	1,567,144	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,845	4,845	152,724	31.52	8
9	Activity Director	3,140	3,481	72,691	20.88	9
10	Activity Assistants	16,372	18,714	204,135	10.91	10
11	Social Service Workers	6,665	7,164	163,060	22.76	11
12	Dietician					12
13	Food Service Supervisor	1,931	2,104	55,162	26.22	13
14	Head Cook	5,682	6,221	75,095	12.07	14
15	Cook Helpers/Assistants	21,138	23,872	244,852	10.26	15
16	Dishwashers					16
17	Maintenance Workers	5,008	5,552	95,853	17.26	17
18	Housekeepers	23,718	25,797	269,409	10.44	18
19	Laundry	10,303	11,330	122,422	10.81	19
20	Administrator	1,944	2,145	122,073	56.91	20
21	Assistant Administrator	1,963	2,143	55,019	25.67	21
22	Other Administrative	481	481	46,779	97.25	22
23	Office Manager					23
24	Clerical	13,333	15,198	302,897	19.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,872	2,097	31,757	15.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	13,149	13,351	237,294	17.77	33
34	TOTAL (lines 1 - 33)	355,891	389,648	\$ 7,085,092 *	\$ 18.18	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	1,164	\$ 46,210	01-03	35
36	Medical Director	Monthly	15,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	33	372	10-03	38
39	Pharmacist Consultant	Monthly	19,216	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,760	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,229	\$ 83,458		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

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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Renaissance at Midway

0041749

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC \$14,554 and Alliance \$1,207
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 5,282 Line 10
- (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. \$ 558,739
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. \$ 29,565 Has any meal income been offset against related costs? No 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? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.