

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0040295</u></p> <p>Facility Name: <u>Renaissance Care Center</u></p> <p>Address: <u>1675 East Ash Street</u> <u>Canton</u> <u>61520</u> <small>Number City Zip Code</small></p> <p>County: <u>Fulton</u></p> <p>Telephone Number: <u>(309) 647-5631</u> Fax # <u>(309) 647-8957</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>2/1/1993</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>							

Facility Name & ID Number Renaissance Care Center

0040295 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	120	Skilled (SNF)	120	43,800	1
2	70	Skilled Pediatric (SNF/PED)	70	25,550	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,579	218	6,417	28,214	8
9	SNF/PED					9
10	ICF	13,759	1,824	1,511	17,094	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,338	2,042	7,928	45,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.33%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO

I. On what date did you start providing long term care at this location? Date started 02/01/1993

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

K. Was the facility certified for Medicare during the reporting year? YES NO If YES, enter number of beds certified 120 and days of care provided 3,073

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	156,334	11,437	19,583	187,354		187,354		187,354		1
2	Food Purchase		199,120		199,120		199,120	(1,978)	197,142		2
3	Housekeeping	194,529	50,241		244,770		244,770	152	244,922		3
4	Laundry	61,235	20,908		82,143		82,143		82,143		4
5	Heat and Other Utilities			149,767	149,767		149,767	1,082	150,849		5
6	Maintenance	73,397	86,770	52,287	212,454		212,454	7,974	220,428		6
7	Other (specify):*										7
8	TOTAL General Services	485,495	368,476	221,637	1,075,608		1,075,608	7,230	1,082,838		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,690,449	131,929	10,667	2,833,045		2,833,045	39,129	2,872,174		10
10a	Therapy	16,661	16,035	2,387	35,083		35,083		35,083		10a
11	Activities	122,253	3,124		125,377		125,377		125,377		11
12	Social Services	34,054		5,497	39,551		39,551		39,551		12
13	CNA Training										13
14	Program Transportation			1,713	1,713		1,713		1,713		14
15	Other (specify):*							6,152	6,152		15
16	TOTAL Health Care and Programs	2,863,417	151,088	26,264	3,040,769		3,040,769	45,281	3,086,050		16
	C. General Administration										
17	Administrative	103,310			103,310		103,310	90,480	193,790		17
18	Directors Fees										18
19	Professional Services			533,229	533,229	(4,000)	529,229	(398,782)	130,447		19
20	Dues, Fees, Subscriptions & Promotions			55,078	55,078		55,078	(29,228)	25,850		20
21	Clerical & General Office Expenses	92,462	4,934	165,529	262,925		262,925	68,896	331,821		21
22	Employee Benefits & Payroll Taxes			570,099	570,099		570,099		570,099		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,304	4,304		4,304	496	4,800		24
25	Other Admin. Staff Transportation			24,412	24,412		24,412	9,656	34,068		25
26	Insurance-Prop.Liab.Malpractice			110,763	110,763		110,763	3,800	114,563		26
27	Other (specify):*							44,588	44,588		27
28	TOTAL General Administration	195,772	4,934	1,463,414	1,664,120	(4,000)	1,660,120	(210,094)	1,450,026		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,544,684	524,498	1,711,315	5,780,497	(4,000)	5,776,497	(157,583)	5,618,914		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.

Facility Name & ID Number

Renaissance Care Center

#0040295

Report Period Beginning:

01/01/14

Ending:

12/31/14

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			99,802	99,802		99,802	252,157	351,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,315	19,315		19,315	437,424	456,739			32
33	Real Estate Taxes					4,000	4,000	64,700	68,700			33
34	Rent-Facility & Grounds			860,681	860,681		860,681	(848,394)	12,287			34
35	Rent-Equipment & Vehicles			8,352	8,352		8,352	7,041	15,393			35
36	Other (specify):*							35,082	35,082			36
37	TOTAL Ownership			988,150	988,150	4,000	992,150	(51,990)	940,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		426,793	449,706	876,499		876,499		876,499			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			358,853	358,853		358,853		358,853			42
43	Other (specify):*	62,605			62,605		62,605	(62,605)	0			43
44	TOTAL Special Cost Centers	62,605	426,793	808,559	1,297,957		1,297,957	(62,605)	1,235,352			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,607,289	951,291	3,508,024	8,066,604		8,066,604	(272,178)	7,794,426			45

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

Facility Name & ID Number Renaissance Care Center

0040295

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	(1,982)	02		4
5	Telephone, TV & Radio in Resident Rooms	(10,005)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(69,300)	30		9
10	Interest and Other Investment Income	(13,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	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	(4,947)	21		18
19	Entertainment				19
20	Contributions	(2,000)	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	(79,643)	21		24
25	Fund Raising, Advertising and Promotional	(32,189)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(745)	20		28
29	Other-Attach Schedule	(77,423)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (291,324)		\$	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)	19,146		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 19,146		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (272,178)		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 Care Center

ID# 0040295

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing	\$ (62,605)	43	1
2	Bank Charges	(10,733)	21	2
3	Theft and Damage Loss	(445)	21	3
4	Non-allowable Legal Expense	(3,667)	19	4
5	State Replacement Tax	(1,000)	21	5
6	Additional R&M	16,288	06	6
7	Miscellaneous Income	(3,064)	21	7
8				8
9				9
10				10
11				11
12	Building Co.			12
13	Accounting Fees	(9,330)	19	13
14				14
15	Amortization HUD Fees	(2,803)	36	15
16				16
17	Bank Charges	(64)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(77,423)	49

Renaissance Care Center

ID# 0040295

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

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	(2,072)		94									(1,978)	2
3	Housekeeping			152									152	3
4	Laundry													4
5	Heat and Other Utilities			1,082									1,082	5
6	Maintenance	6,283		1,691									7,974	6
7	Other (specify):*													7
8	TOTAL General Services	4,211		3,019									7,230	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			39,129									39,129	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,152									6,152	15
16	TOTAL Health Care and Programs			45,281									45,281	16
	C. General Administration													
17	Administrative			90,480									90,480	17
18	Directors Fees													18
19	Professional Services	(12,997)	12,596	(398,381)									(398,782)	19
20	Fees, Subscriptions & Promotions	(34,934)		5,706									(29,228)	20
21	Clerical & General Office Expenses	(99,896)	64	168,728									68,896	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			496									496	24
25	Other Admin. Staff Transportation			9,656									9,656	25
26	Insurance-Prop.Liab.Malpractice			3,800									3,800	26
27	Other (specify):*			44,588									44,588	27
28	TOTAL General Administration	(147,827)	12,660	(74,927)									(210,094)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(143,616)	12,660	(26,627)									(157,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance Care Center

0040295

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	(69,300)	310,231	11,226									252,157	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,000)	450,411	13									437,424	32
33	Real Estate Taxes		64,700										64,700	33
34	Rent-Facility & Grounds		(858,081)	9,687									(848,394)	34
35	Rent-Equipment & Vehicles			7,041									7,041	35
36	Other (specify):*	(2,803)	37,885										35,082	36
37	TOTAL Ownership	(85,103)	5,146	27,967									(51,990)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(62,605)											(62,605)	43
44	TOTAL Special Cost Centers	(62,605)											(62,605)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(291,324)	17,806	1,340									(272,178)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 858,081	Renaissance Care Center Property LLC	100.00%	\$	\$ (858,081)	1
2	V	32 Interest Income	92	Renaissance Care Center Property LLC	100.00%		(92)	2
3	V	19 Accounting Fees		Renaissance Care Center Property LLC	100.00%	9,330	9,330	3
4	V	36 Amortization	28,367	Renaissance Care Center Property LLC	100.00%	2,803	(25,564)	4
5	V	30 Depreciation		Renaissance Care Center Property LLC	100.00%	319,681	319,681	5
6	V	32 Interest Expense		Renaissance Care Center Property LLC	100.00%	450,503	450,503	6
7	V	33 Real Estate Taxes		Renaissance Care Center Property LLC	100.00%	64,700	64,700	7
8	V	36 MIP Expense		Renaissance Care Center Property LLC	100.00%	63,449	63,449	8
9	V	19 Legal Fees	734	Renaissance Care Center Property LLC	100.00%		(734)	9
10	V	30 Sale of property	9,450	Renaissance Care Center Property LLC	100.00%		(9,450)	10
11	V	19 Appraisal Fee		Renaissance Care Center Property LLC	100.00%	4,000	4,000	11
12	V	21 Bank Charges		Renaissance Care Center Property LLC	100.00%	64	64	12
13	V							13
14	Total		\$ 896,724			\$ 914,530	\$ * 17,806	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	2 <u>FOOD</u>	\$	<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	\$ 94	\$	94	15
16	V	3 <u>HOUSEKEEPING</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	152		152	16
17	V	5 <u>UTILITIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	1,082		1,082	17
18	V	6 <u>REPAIRS AND MAINTENANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	1,691		1,691	18
19	V	10 <u>NURSING</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	39,129		39,129	19
20	V	15 <u>EMP. BEN. HEALTHCARE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	6,152		6,152	20
21	V	17 <u>ADMINISTRATIVE SALARIES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	36,666		36,666	21
22	V	19 <u>PROFESSIONAL FEES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	42,707		42,707	22
23	V	20 <u>DUES, FEES, SUBSCRIPTIONS</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	5,706		5,706	23
24	V	21 <u>SALARIES - CLERICAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	139,112		139,112	24
25	V	21 <u>OFFICE EXPENSES</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	29,616		29,616	25
26	V	24 <u>SEMINAR EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	496		496	26
27	V	25 <u>AUTO & TRAVEL EXPENSE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	9,656		9,656	27
28	V	26 <u>INSURANCE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	3,800		3,800	28
29	V	27 <u>EMP. BEN. GEN. ADMIN.</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	33,462		33,462	29
30	V	30 <u>DEPRECIATION</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	11,226		11,226	30
31	V	32 <u>INTEREST</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	13		13	31
32	V	34 <u>RENT</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	9,687		9,687	32
33	V	35 <u>EQUIPMENT RENTAL</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	797		797	33
34	V	35 <u>AUTO LEASE</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	6,244		6,244	34
35	V								35
36	V	17 <u>ADMIN COMP - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	53,814		53,814	36
37	V	27 <u>EMP. BEN. - B. ALTER</u>		<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%	11,126		11,126	37
38	V	19 <u>HOME OFFICE EXPENSE</u>	441,088	<u>CERTIFIED HEALTH MANAGEMENT</u>	100.00%			(441,088)	38
39	Total		\$ 441,088			\$ 442,428	\$ *	1,340	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 (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 (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 (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 (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 (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.

Facility Name & ID Number

Renaissance Care Center

0040295

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	BRADLEY ALTER & BETH ALTER	37.0849	DANVILLE CARE CENTER, LTD.	DANVILLE	RENAISSANCE CARE CENTER	SKOKIE	BUILDING CO.	1
2	HOWARD D GELLER TRUST	47.417%	GLENWOOD HEALTHCARE & REHAB, INC.	GLENWOOD	CERTIFIED HEALTH MGMT.	SKOKIE, ILLINOIS	MANAGEMENT	2
3	MR. LAURENCE ZUNG	3.506%	PRAIRIE VIEW CARE CENTER OF LEWISTOWN, INC.	LEWISTOWN				3
4	MRS. IRENE SANDLER	2.768%	PAXTON HEALTHCARE AND REHAB	PAXTON				4
5	MR. IRA SHYMAN	1.845%	PONTIAC HEALTHCARE AND REHAB	PONTIAC				5
6	MR. JOSEPH L ASHMAN	1.845%						6
7	RABBI MORRIS NOBLE	1.845%						7
8	JENNIFER CHOW	1.845%						8
9	JULIE BRUM	1.845%						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Renaissance Care Center

0040295

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 Care Center # 0040295 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	Bradley M. Alter	Owner	Administration	37.0849	See Attached	13.45	26.90%	Alloc. Salary	\$ 53,814	17-7	1
2	Daniel Alter	Relative	Financial	0.00	See Attached	9.42	26.91%	Alloc. Salary	6,383	21-7	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	\$ 60,197		13

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

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

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 Care Center

0040295

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 CERTIFIED HEALTH MANAGEMENT
 Street Address 3856 W. OAKTON
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	FOOD	PATIENT DAYS	168,387	6	\$ 349	45,308	\$ 94	1	
2	3	HOUSEKEEPING	PATIENT DAYS	168,387	6	566	45,308	152	2	
3	5	UTILITIES	PATIENT DAYS	168,387	6	4,022	45,308	1,082	3	
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	168,387	6	6,283	45,308	1,691	4	
5	10	NURSING	PATIENT DAYS	168,387	6	145,423	145,423	39,129	5	
6	15	EMP. BEN. HEALTHCARE	PATIENT DAYS	168,387	6	22,862	45,308	6,152	6	
7	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	168,387	6	136,269	136,269	36,666	7	
8	19	PROFESSIONAL FEES	PATIENT DAYS	168,387	6	158,722	45,308	42,707	8	
9	20	DUES, FEES, SUBSCRIPTIONS	PATIENT DAYS	168,387	6	21,206	45,308	5,706	9	
10	21	SALARIES - CLERICAL	PATIENT DAYS	168,387	6	517,009	517,009	139,112	10	
11	21	OFFICE EXPENSES	PATIENT DAYS	168,387	6	110,068	45,308	29,616	11	
12	24	SEMINAR EXPENSE	PATIENT DAYS	168,387	6	1,845	45,308	496	12	
13	25	AUTO & TRAVEL EXPENSE	PATIENT DAYS	168,387	6	35,887	45,308	9,656	13	
14	26	INSURANCE	PATIENT DAYS	168,387	6	14,124	45,308	3,800	14	
15	27	EMP. BEN. GEN. ADMIN.	PATIENT DAYS	168,387	6	124,361	45,308	33,462	15	
16	30	DEPRECIATION	PATIENT DAYS	168,387	6	41,720	45,308	11,226	16	
17	32	INTEREST	PATIENT DAYS	168,387	6	49	45,308	13	17	
18	34	RENT	PATIENT DAYS	168,387	6	36,000	45,308	9,687	18	
19	35	EQUIPMENT RENTAL	PATIENT DAYS	168,387	6	2,961	45,308	797	19	
20	35	AUTO LEASE	PATIENT DAYS	168,387	6	23,207	45,308	6,244	20	
21									21	
22	17	ADMIN COMP - B. ALTER	AVERAGE HOURS WORKI	50	6	200,000	200,000	13.45	53,814	22
23	27	EMP. BEN. - B. ALTER	AVERAGE HOURS WORKI	50	6	41,351		13.45	11,126	23
24									24	
25	TOTALS					\$ 1,644,284	\$ 998,701	\$ 442,428	25	

Facility Name & ID Number Renaissance Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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 Care Center

0040295

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		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1		Enloe		X	Note Payable	\$1,444.11	4/7/11	\$ 88,530	\$ 15,036		5.7500	\$ 1,619	1						
2		HUD		X	Mortgage				12,428,196			450,503	2						
3		HUD Refinancing		X	Refi				181,318				3						
4													4						
5													5						
		Working Capital																	
6		Bank Financial		X	Line of Credit				878,683		4.5000	16,076	6						
7		Insurance Financing		X								1,620	7						
8		See Supplemental Schedule										13	8						
9		TOTAL Facility Related				\$1,444.11		\$ 88,530	\$ 13,503,233			\$ 469,832	9						
		B. Non-Facility Related*																	
10		Interest Income		X								(13,000)	10						
11		Interest Income- Build Co		X								(92)	11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$ (13,092)	14						
15		TOTALS (line 9+line14)						\$ 88,530	\$ 13,503,233			\$ 456,740	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,449 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 Care Center

0040295

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**					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							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	TOTAL Long-Term																
Working Capital																	
8	Officer's Loan	X					\$	\$			\$ 13						
9																	
10																	
11																	
12																	
13																	
14	TOTAL Working Capital										13						
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.		\$	62,916		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.)		\$	62,866		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(50)		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	64,750		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.)		\$	4,000		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.		\$	68,700		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>46,135</u>	8	FOR BHF USE ONLY	
	2010	<u>56,648</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>60,172</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>61,084</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>62,866</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2014 Accrual - \$62,866 x 1.03 = \$64,750					

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 Care Center COUNTY Fulton
 FACILITY IDPH LICENSE NUMBER 0040295
 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>09-08-25-101-025</u>	<u>Long-Term Care Property</u>	\$ <u>62,865.80</u>	\$ <u>62,865.80</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>62,865.80</u></u>	\$ <u><u>62,865.80</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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 Care Center

0040295 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			\$ 291,000	1
2					2
3	TOTALS			\$ 291,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	190	1993	1976	\$ 5,238,000	\$ 310,231	27.5	\$ 190,454	\$ (119,777)	\$ 2,800,987	4
5			2010	534,152		27.5	19,424	19,424	97,120	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	9,646		20			9,646	9
10	Various		1994	9,445		20	324	324	9,445	10
11	Various		1995	11,173		20	559	559	10,894	11
12	Various		1997	23,578		20	1,179	1,179	20,631	12
13	Various		1998	47,834		20	2,392	2,392	39,463	13
14	Various		1999	21,162		20	1,058	1,058	16,665	14
15	Various		2000	9,146		20	457	457	6,669	15
16	Various		2001	48,446		20	2,422	2,422	32,701	16
17	Various		2002	2,252		20	113	113	1,408	17
18	Various		2003	16,990		20	850	850	9,769	18
19	Various		2004	4,707		20	235	235	2,471	19
20	Various		2005	30,220		20	1,511	1,511	14,480	20
21	Various		2006	52,027		20	2,601	2,601	22,111	21
22	Various		2007	5,890		20	295	295	2,307	22
23	Various		2008	23,192		20	2,319	2,319	15,655	23
24	Various		2010	26,646		20	3,843	3,843	17,894	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Renaissance Care Center

0040295

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		675,932			33,799	33,799	219,435	67
68		32,481	7,778		1,446	(6,332)	22,995	68
69			99,802			(99,802)		69
70		\$ 6,822,919	\$ 417,811		\$ 265,280	\$ (152,531)	\$ 3,372,745	70

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

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		\$ 6,822,919	\$ 417,811		\$ 265,280	\$ (152,531)	\$ 3,372,745	1
2	Airway Clearance Device	2011	15,800		20	3,160	3,160	12,640	2
3	Air Pulse Generator System	2011	4,400		20	880	880	3,373	3
4	Thru Wall A/C	2011	7,503		20	1,501	1,501	5,252	4
5	Roof Top Unit	2011	5,000		20	250	250	875	5
6	Roof Top Unit	2011	4,893		20	245	245	836	6
7	Water Heater	2012	6,595		20	330	330	824	7
8	Thru Wall A/C Unit	2012	2,695		20	385	385	963	8
9	Video Monitor System	2012	16,353		20	3,271	3,271	8,722	9
10	Vinyl Flooring, Cove Base - Pt Room	2012	10,579		20	2,116	2,116	4,761	10
11	Menards - Sink, Faucet, Granite - Therapy Room - 100 Wing	2012	2,657		20	531	531	1,240	11
12	Walls, Flooring, Millwork, Handrails-Lobby,Activity,Concierge,Nt	2012	2,500		20	125	125	281	12
13	Repair Sewer Line	2012	4,314		20	216	216	503	13
14	Sealcoating	2012	6,000		20	300	300	675	14
15	Replace 2 Sets Of Doors - Facility Entry - Front Of Building	2012	5,372		20	269	269	560	15
16	Fluorescent Sign Display	2013	7,528		20	502	502	627	16
17	Electric Wiring/Breakers/Directional Boring	2013	4,305		20	215	215	251	17
18	Water Heater	2013	11,620		20	581	581	629	18
19	Duplex Outlets And Hallway Light Rework	2013	3,350		20	168	168	237	19
20	Removable Signage	2013	3,843		20	769	769	1,473	20
21	Roof Wall Area Repair	2013	2,926		20	146	146	219	21
22	New Alarm/Camera/Monitoring System	2014	3,259		20	652	652	652	22
23	Firewall Upgrade	2014	2,500		20	73	73	73	23
24	Roofing Membrane Repairs	2014	9,500		20	79	79	79	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491	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		\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491	34

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

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		\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491	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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 6,966,410	\$ 417,811		\$ 282,041	\$ (135,770)	\$ 3,418,491		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	
	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	Fire Protection Line	2009	15,714		20	786	786	4,802	9
10	Flooring - Econocare	2009	18,657		20	933	933	13,371	10
11	Windows	2009	96,772		20	4,839	4,839	39,516	11
12	Tile Work	2009	4,000		20	200	200	1,667	12
13	Blacktop	2009	30,000		20	1,500	1,500	9,333	13
14	Masonrv	2009	17,860		20	893	893	4,465	14
15	Fire Protection	2010	105,000		20	5,250	5,250	40,250	15
16	Wallcovering, ceramic tile, carpet, laminate nurses station	2010	84,876		20	4,244	4,244	56,584	16
17	ALTA Survey (Engineer)	2010	2,659		20	133	133	1,019	17
18	Window Treatments	2010	6,379		20	319	319	2,445	18
19	Installation of Shingles	2010	16,650		20	833	833	4,164	19
20	Circuit Extension	2011	8,500		20	425	425	2,550	20
21	Walls, ceiling tile, flooring, millwork, lighting, cabinetrv, handrails, wi	2012	248,972		20	12,449	12,449	37,347	21
22	Carpet Tile	2013	6,409		20	320	320	640	22
23	Oak Cabinets	2013	6,210		20	311	311	622	23
24	Decorative Cornices	2013	2,859		20	143	143	286	24
25	Ceramic Floor Tiles	2013	4,415		20	221	221	374	25
26	Depreciation								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 675,932	\$		\$ 33,799	\$ 33,799	\$ 219,435	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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 675,932	\$		\$ 33,799	\$ 33,799	\$ 219,435		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)	\$ 675,932	\$		\$ 33,799	\$ 33,799	\$ 219,435		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									3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - Certified Health Management	1997	25,353	650	20	1,268	618	22,817	9
10	Allocated - Certified Health Management	2014	7,128	7,128	20	178	(6,950)	178	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)		\$ 32,481	\$ 7,778		\$ 1,446	\$ (6,332)	\$ 22,995	34

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

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		\$ 32,481	\$ 7,778		\$ 1,446	\$ (6,332)	\$ 22,995	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		\$ 32,481	\$ 7,778		\$ 1,446	\$ (6,332)	\$ 22,995	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	\$ 479,900	\$ 1,087	\$ 65,631	\$ 64,544	10	\$ 253,116	71
72	Current Year Purchases	48,325	2,361	3,455	1,094	10	3,455	72
73	Fully Depreciated Assets	577,921		831	831	10	577,921	73
74								74
75	TOTALS	\$ 1,106,146	\$ 3,448	\$ 69,917	\$ 66,469		\$ 834,492	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VEHICLES	1996	\$ 5,840	\$	\$	\$	5	\$ 5,840	76
77		VEHICLE	2000	13,900				5	13,900	77
78		VEHICLE	2003	18,859				5	18,859	78
79										79
80	TOTALS			\$ 38,599	\$	\$	\$		\$ 38,599	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,402,156	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 421,259	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 351,959	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (69,300)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,291,582	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.

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				2,600			5
6	Allocated from Certified Health Management				9,687			6
7	TOTAL				\$ 12,287			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: \$ 7,067

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Certified Health Management		\$	\$ 6,244	17
18	Facility	Toyota Camry; 2014		2,082	18
19					19
20					20
21	TOTAL		\$	\$ 8,326	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 Care Center # 0040295 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	201,716	\$		\$	201,716	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				30,988				30,988	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				217,002				217,002	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					107,629			107,629	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							319,164			319,164	13
14	TOTAL			\$		\$	449,706	\$	426,793	\$	876,499	14

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

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning: 01/01/14

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 64,095	\$ 234,926	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,234,053	2,234,053	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,329	98,329	6
7	Other Prepaid Expenses	561	52,819	7
8	Accounts Receivable (owners or related parties)	1,116,747	1,116,747	8
9	Other(specify):	1,885	1,885	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,515,670	\$ 3,738,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		291,000	13
14	Buildings, at Historical Cost		5,772,152	14
15	Leasehold Improvements, at Historical Cost	449,614	1,151,590	15
16	Equipment, at Historical Cost	716,217	1,167,926	16
17	Accumulated Depreciation (book methods)	(765,631)	(4,359,366)	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):	268,459	565,377	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 668,659	\$ 4,588,679	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,184,329	\$ 8,327,438	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,118,345	\$ 1,118,346	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	893,719	1,075,037	29
30	Accrued Salaries Payable	236,774	236,774	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,213	18,213	31
32	Accrued Real Estate Taxes(Sch.IX-B)		64,750	32
33	Accrued Interest Payable	2,638	39,941	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	98	98	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	126,313	126,313	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,396,100	\$ 2,679,472	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,428,196	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,004,674	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 13,432,870	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,396,100	\$ 16,112,342	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,788,229	\$ (7,784,904)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,184,329	\$ 8,327,438	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 499,145	1
2	Restatements (describe):		2
3			3
4	Prior Year's Journal Entry Adjustment	103,932	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 603,077	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,185,152	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,185,152	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)	\$ 1,788,229	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	\$ 8,092,454	1
2	Discounts and Allowances for all Levels	753,165	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,845,619	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	91,227	6
7	Oxygen	1,776	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 93,003	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	1,982	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,343	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	363	19
20	Radiology and X-Ray	592	20
21	Other Medical Services	2,564	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,844	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,000	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,000	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	290,290	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 290,290	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,251,756	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,075,608	31
32	Health Care	3,040,769	32
33	General Administration	1,664,120	33
B. Capital Expense			
34	Ownership	988,150	34
C. Ancillary Expense			
35	Special Cost Centers	939,104	35
36	Provider Participation Fee	358,853	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,066,604	40
41	Income before Income Taxes (line 30 minus line 40)**	1,185,152	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,185,152	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,781,200	44
45	Private Pay - Net Inpatient Revenue	363,597	45
46	Medicare - Net Inpatient Revenue	1,431,260	46
47	Other-(specify) <u>Managed Care, Hospice</u>	907,133	47
48	Other-(specify) <u>Exceptional Care, Pediatric</u>	4,362,429	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,845,619	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 Care Center

0040295

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	1,807	1,823	\$ 83,991	\$ 46.07	1
2	Assistant Director of Nursing	1,896	1,912	57,067	29.85	2
3	Registered Nurses	24,310	24,456	669,655	27.38	3
4	Licensed Practical Nurses	25,464	26,080	613,410	23.52	4
5	CNAs & Orderlies	99,706	102,075	1,221,059	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,044	1,044	16,661	15.96	8
9	Activity Director	1,948	1,965	27,995	14.25	9
10	Activity Assistants	2,878	2,908	46,780	16.09	10
11	Social Service Workers	2,133	2,152	34,054	15.82	11
12	Dietician					12
13	Food Service Supervisor	1,973	1,990	38,721	19.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,716	6,742	69,057	10.24	15
16	Dishwashers	4,189	4,344	48,556	11.18	16
17	Maintenance Workers	4,326	4,428	73,397	16.58	17
18	Housekeepers	17,186	17,300	194,529	11.24	18
19	Laundry	5,828	5,974	61,235	10.25	19
20	Administrator	1,705	1,720	103,310	60.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,705	1,720	47,444	27.58	23
24	Clerical	2,840	2,866	45,018	15.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,842	1,858	47,478	25.55	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,252	3,323	45,267	13.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,429	4,466	62,605	14.02	33
34	TOTAL (lines 1 - 33)	217,177	221,146	\$ 3,607,289 *	\$ 16.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	347	\$ 19,583	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	42	1,049	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	125	9,618	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	40	2,387	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	100	4,152	12-03	45
46	Other(specify)				46
47	Psychosocial Consulting	15	1,345	12-03	47
48					48
49	TOTAL (lines 35 - 48)	669	\$ 44,134		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												
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9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Renaissance Care Center

0040295

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,123 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 358,853
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,982
- (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% Ln14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.