FOR BHF USE

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0040295

Facility Name: Renaissance Care Center

Address: 1675 East Ash Street (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 647-5631 **Fax #** (309) 647-8957

HFS ID Number:

Date of Initial License for Current Owners: 2/1/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2	70	Skilled Pediatric (SNF/PED)	70	25,620	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	69,540	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,291	210	5,022	10,523	8
9	SNF/PED	23,128			23,128	9
10	ICF	6,911	3,138		10,049	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,330	3,348	5,022	43,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.84%

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 [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 2/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 2,962

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,670	10,889	18,847	202,406		202,406		202,406			1
2	Food Purchase		204,747		204,747		204,747	(2)	204,745			2
3	Housekeeping	170,384	43,615		213,999		213,999		213,999			3
4	Laundry	56,115	24,865		80,980		80,980		80,980			4
5	Heat and Other Utilities			137,062	137,062		137,062	927	137,989			5
6	Maintenance	75,757	46,293	32,359	154,409		154,409	4,419	158,828			6
7	Other (specify):* Waste Removal			13,705	13,705		13,705		13,705			7
8	TOTAL General Services	474,926	330,409	201,973	1,007,308		1,007,308	5,344	1,012,652			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	2,929,250	445,444	15,762	3,390,456		3,390,456	105,318	3,495,774			10
10a	Therapy	25,522		1,260	26,782		26,782		26,782			10a
11	Activities	86,822		7,698	94,520		94,520		94,520			11
12	Social Services	73,826		2,808	76,634		76,634		76,634			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Alloc. Emp Benefits							17,986	17,986			15
16	TOTAL Health Care and Programs	3,115,420	445,444	34,128	3,594,992		3,594,992	123,304	3,718,296			16
	C. General Administration											
17	Administrative	78,978		525,084	604,062		604,062	(449,911)	154,151			17
18	Directors Fees											18
19	Professional Services			111,576	111,576		111,576	6,285	117,861			19
20	Dues, Fees, Subscriptions & Promotions			21,542	21,542		21,542	1,767	23,309			20
21	Clerical & General Office Expenses	94,381	5,160	91,902	191,443		191,443	164,930	356,373			21
22	Employee Benefits & Payroll Taxes			656,060	656,060		656,060		656,060			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,842	23,842		23,842	10,615	34,457			24
25	Other Admin. Staff Transportation			12,173	12,173		12,173	5,206	17,379			25
26	Insurance-Prop.Liab.Malpractice			156,368	156,368		156,368	1,020	157,388			26
27	Other (specify):* Alloc. Emp Benefits							36,458	36,458			27
28	TOTAL General Administration	173,359	5,160	1,598,547	1,777,066		1,777,066	(223,630)	1,553,436			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,763,705	781,013	1,834,648	6,379,366		6,379,366	(94,982)	6,284,384			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Renaissance Care Center #0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			102,000	102,000		102,000	251,396	353,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,996	56,996		56,996	394,287	451,283			32
33	Real Estate Taxes							69,815	69,815			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(892,066)	7,934			34
35	Rent-Equipment & Vehicles			13,358	13,358		13,358	1,972	15,330			35
36	Other (specify):* Mtg Insurance							61,632	61,632			36
37	**TOTAL Ownership**			1,072,354	1,072,354		1,072,354	(112,964)	959,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,981	351,917	457,898		457,898		457,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			366,000	366,000		366,000		366,000			42
43	Other (specify):* See Att Sch 4A	50,928		167,975	218,903		218,903	(206,254)	12,649			43
44	**TOTAL Special Cost Centers**	50,928	105,981	885,892	1,042,801		1,042,801	(206,254)	836,547			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,814,633	886,994	3,792,894	8,494,521		8,494,521	(414,200)	8,080,321			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Renaissance Care Center

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory Expense			9,878	9,878		9,878		9,878			
	Radiology Expenses			2,771	2,771		2,771		2,771			
	Non-Allowable Expenses	50,928		155,326	206,254		206,254	(206,254)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special Cost Centers	50,928	0	167,975	218,903	0	218,903	(206,254)	12,649			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,953)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(52,009)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	43		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	(20)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,305)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(114,000)	43		24
25	Fund Raising, Advertising and Promotional	(25,261)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(68,665)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (277,327)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 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)	(136,873)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (136,873)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (414,200)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Renaissance Care Center

ID# 0040295

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	(50,928)	43	1
2	Marketer Car Lease	(4,996)	35	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12	Building Co.			12
13	Accounting Fees	(8,740)	19	13
14	Admin Expense	(4,001)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(68,665)		49

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs and Maintenance	$	Renaissance Care Center Property LLC	100.00%	$ 4,173	$ 4,173	1
2	V	21	Office Expense		Renaissance Care Center Property LLC	100.00%	4,001	4,001	2
3	V	19	Professional Services		Renaissance Care Center Property LLC	100.00%	8,740	8,740	3
4	V	30	Depreciation		Renaissance Care Center Property LLC	100.00%	303,405	303,405	4
5	V	32	Interest	87	Renaissance Care Center Property LLC	100.00%	394,374	394,287	5
6	V	33	Real Estate Taxes		Renaissance Care Center Property LLC	100.00%	69,815	69,815	6
7	V	34	Rent-Facility & Grounds	900,000	Renaissance Care Center Property LLC			(900,000)	7
8	V	36	Mortgage Insurance		Renaissance Care Center Property LLC		61,632	61,632	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 900,087			$ 846,140	$ * (53,947)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Certified Health Management, Inc.	100.00%	$ 927	$ 927	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	246	246	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	105,318	105,318	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	17,986	17,986	18
19	V	17	Administrative	525,084	Certified Health Management, Inc.	100.00%	75,173	(449,911)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	7,590	7,590	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	1,787	1,787	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	164,930	164,930	22
23	V	24	Travel and Seminar		Certified Health Management, Inc.	100.00%	10,615	10,615	23
24	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	5,206	5,206	24
25	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	1,020	1,020	25
26	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	36,458	36,458	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	7,934	7,934	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	6,968	6,968	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			$ 525,084			$ 442,158	$ * (82,926)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	37.085%	Glenwood Healthcare & Rehab	Glenwood	Renaissance Care	Skokie	Lessor	1
2	Howard A. Geller & Rita Geller	47.417%	Prairie View Care Center of Lewistown	Lewistown	Center Property LLC			2
3	Laurence Zung	3.506%	Danville Care Center	Danville	Certified Health	Skokie	Management	3
4	Irene Sandler	2.768%	Paxton Healthcare and Rehab	Paxton	Management, Inc.			4
5	Ira Shyman	1.845%	Pontiac Healthcare and Rehab	Pontiac				5
6	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
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel Alter	Relative	Financial	0.00	See Att Sch 7A	8.82	22.05	Alloc. Salary	$ 11,160	L21, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	8.82	22.05	Alloc. Salary	14,731	L21, C7	2
3	Bradley Alter	Owner	Administration	37.085	See Att Sch 7A	11.02	22.04	Alloc. Salary	40,770	L17, C7	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	$ 66,661		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: Certified Health Management, Inc.
Street Address: 3856 W. Oakton
City / State / Zip Code: Skokie, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	198,295	6	$ 4,208	$	43,700	$ 927	1
2	6	Maintenance	Census Days	198,295	6	1,116		43,700	246	2
3	10	Nursing and Medical Records	Census Days	198,295	6	477,896	477,896	43,700	105,318	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	198,295	6	81,613		43,700	17,986	4
5	17	Administrative	Census Days	198,295	6	341,110	341,110	43,700	75,173	5
6	19	Professional Services	Census Days	198,295	6	34,439		43,700	7,590	6
7	20	Dues, Fees, Subs & Promo	Census Days	198,295	6	8,110		43,700	1,787	7
8	21	Clerical & Gen Office Expenses	Census Days	198,295	6	748,394	627,598	43,700	164,930	8
9	24	Travel and Seminar	Census Days	198,295	6	48,168		43,700	10,615	9
10	25	Other Admin Staff Transportatior	Census Days	198,295	6	23,623		43,700	5,206	10
11	26	Ins.-Prop, Liab, Malpractice	Census Days	198,295	6	4,628		43,700	1,020	11
12	27	Emp Benefit Alloc-Gen Admin	Census Days	198,295	6	165,432		43,700	36,458	12
13	34	Rent-Facility & Grounds	Census Days	198,295	6	36,000		43,700	7,934	13
14	35	Rent-Equipment & Vehicle	Census Days	198,295	6	31,619		43,700	6,968	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,006,356	$ 1,446,604		$ 442,158	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 12,240,335			$ 391,571	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				984,020		4.5000	54,561	6
7	Insurance Financing										2,435	7
8												8
9	TOTAL Facility Related						$	$ 13,224,355			$ 448,567	9
	B. Non-Facility Related*											
10							Amortization Expense				2,803	10
11							Interest Income Offset				(87)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,716	14
15	TOTALS (line 9+line14)						$	$ 13,224,355			$ 451,283	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 61,632 Line # 36

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 65,250	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.)	2015	$ 66,534	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,284	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 68,531	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,815	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	60,172	8
	2012	61,084	9
	2013	62,866	10
	2014	63,331	11
	2015	66,534	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance Care Center COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT Bruce Harris

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-25-101-025	Long-Term Care Property	$ 66,534.48	$ 66,534.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,534.48	$ 66,534.48

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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			$ 281,277	1
2					2
3	TOTALS			$ 281,277	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		1993	1976	$ 5,238,000	$	27.5	$ 190,473	$ 190,473	$ 3,181,914	4
5				2010	534,152		27.5	19,424	19,424	135,968	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	9,646		20			9,646	9
10	Various			1994	9,445		20			9,445	10
11	Various			1995	11,173		20			11,173	11
12	Various			1997	23,578		20	1,179	1,179	22,989	12
13	Various			1998	47,834		20	2,392	2,392	44,247	13
14	Various			1999	21,162		20	1,058	1,058	18,781	14
15	Various			2000	9,146		20	457	457	7,583	15
16	Various			2001	48,446		20	2,422	2,422	37,545	16
17	Various			2002	2,252		20	113	113	1,633	17
18	Various			2003	16,990		20	850	850	11,469	18
19	Various			2004	4,707		20	235	235	2,942	19
20	Various			2005	30,220		20	1,511	1,511	17,502	20
21	Various			2006	52,027		20	2,601	2,601	27,314	21
22	Various			2007	5,890		20	295	295	2,896	22
23	Various			2008	23,192		20	1,160	1,160	19,134	23
24	Various			2010	26,646		20	1,332	1,332	21,279	24
25	Various			2011	37,596		20	1,880	1,880	30,892	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	
37	Water Heater	2012	$ 6,595	$	20	$ 330	$ 330	$ 1,484	37
38	Thru Wall A/C Unit	2012	2,695		20	135	135	1,483	38
39	Video Monitor System	2012	16,353		20	818	818	12,810	39
40	Vinyl Flooring, Cove Base - Pt Room	2012	10,579		20	529	529	7,405	40
41	Menards - Sink, Faucet, Granite - Therapy Room - 100 Wing	2012	2,657		20	133	133	1,904	41
42	Walls, Flooring, Millwork, Handrails-Lobby,Activity,Concierge,N	2012	2,500		20	125	125	531	42
43	Repair Sewer Line	2012	4,314		20	216	216	935	43
44	Sealcoating	2012	6,000		20	300	300	1,275	44
45	Replace 2 Sets Of Doors - Facility Entry - Front Of Building	2012	5,372		20	269	269	1,097	45
46	Fluorescent Sign Display	2013	7,528		20	376	376	1,505	46
47	Electric Wiring/Breakers/Directional Boring	2013	4,305		20	215	215	681	47
48	Water Heater	2013	11,620		20	581	581	1,791	48
49	Duplex Outlets And Hallway Light Rework	2013	3,350		20	168	168	573	49
50	Removable Signage	2013	3,843		20	192	192	2,434	50
51	Roof Wall Area Repair	2013	2,926		20	146	146	512	51
52	New Alarm/Camera/Monitoring System	2014	3,259		20	163	163	1,467	52
53	Firewall Upgrade	2014	2,500		20	125	125	323	53
54	East Wing Shower Remodel-Demo ceiling, walls, flooring.	2015	30,752		20	1,538	1,538	1,792	54
55	Widen doorway and replace door. Install exhaust fans, faucets,								55
56	waterproof system, tile flooring and walls, grab bars, drop								56
57	ceiling, shower heat duct, can lights. Install washer box, hoses,								57
58	floor box and pipe for tub.								58
59									59
60	West Wing Shower Remodel-Demo ceiling, walls, flooring.	2015	16,000		20	800	800	1,000	55
61	Widen doorway and replace door. Install exhaust fans, faucets,								61
62	waterproof system, tile flooring and walls, grab bars, drop								62
63	ceiling, shower heat duct. Raise floor drain and re-pour.								63
64									64
65	Install Rooftop Unit	2015	5,870		20	294	294	441	65
66	Roof Over Front Entrance	2016	10,180		20	509	509	509	66
67	Roof Repairs-Kitchen/Dining/Medical Records	2016	2,780		20	139	139	139	67
68									68
69	Financial Statement Deprciation			102,000			(102,000)		69
70	TOTAL (lines 4 thru 69)		$ 6,314,080	$ 102,000		$ 235,483	$ 133,483	$ 3,656,443	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 12A, Carried Forward		$ 6,314,080	$ 102,000		$ 235,483	$ 133,483	$ 3,656,443	1
2									2
3	Leasehold Improvements (Real Estate Entity):								3
4	Fire Protection Line	2009	15,714		20	786	786	6,374	4
5	Flooring - Econocare	2009	18,657		20	933	933	15,237	5
6	Windows	2009	96,772		20	4,839	4,839	49,194	6
7	Tile Work	2009	4,000		20	200	200	2,067	7
8	Blacktop	2009	30,000		20	1,500	1,500	12,333	8
9	Masonry	2009	17,860		20	893	893	6,251	9
10	Fire Protection	2010	105,000		20	5,250	5,250	50,750	10
11	Wallcovering, ceramic tile, carpet, laminate nurses station	2010	84,876		20	4,244	4,244	65,072	11
12	ALTA Survey (Engineer)	2010	2,659		20	133	133	1,285	12
13	Window Treatments	2010	6,379		20	319	319	3,083	13
14	Installation of Hickory colored GAF Architectural Shingles	2010	16,650		20	833	833	5,830	14
15	Installation of 40 circuit extension plugmold strips in 20 rooms	2011	8,500		20	425	425	3,400	15
16	Walls,ceiling tile, flooring,millwork,lighting,cabinetry,handrails,w	2012	248,972		20	12,449	12,449	62,245	16
17	Carpet Tile - 100 Wing Resident Rooms	2013	6,409		20	320	320	1,280	17
18	Oak Cabinets - 100 Wing Remodeling	2013	6,210		20	311	311	1,244	18
19	Decorative Cornices - 100 Wing Resident Rooms	2013	2,859		20	143	143	572	19
20	Ceramic Floor Tiles	2013	4,415		20	221	221	816	20
21	Roofing Membrane Repairs	2014	9,500		20	475	475	950	21
22	Doors	2015	6,060		20	303	303	606	22
23	Wander Guard	2015	2,557		20	128	128	256	23
24	Sidewalk & Gazebo	2015	17,300		20	865	865	1,730	24
25	West Wing Shower Remodel-Frame Walls, Insulate Attic, Plumbing,								25
26	Electric, Exhaust, Painting	2016	18,975		20	949	949	949	26
27									27
28									28
29									29
30									30
31									31
32	Allocated from Certified Health Management	1997	20,767		20			20,767	32
33	Allocated from Certified Health Management	2014	5,838		20	292	292	1,022	33
34	TOTAL (lines 1 thru 33)		$ 7,071,009	$ 102,000		$ 272,294	$ 170,294	$ 3,969,756	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 783,525	$	$ 78,353	$ 78,353	10	$ 672,674	71
72	Current Year Purchases	27,488		2,749	2,749	10	2,749	72
73	Fully Depreciated Assets	327,433				10	327,433	73
74								74
75	TOTALS	$ 1,138,446	$	$ 81,102	$ 81,102		$ 1,002,856	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		Vehicle	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)	$ 8,529,331	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 353,396	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 251,396	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,011,211	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Allocated from Management Co.				7,934			5
6								6
7	TOTAL				$ 7,934 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 8,362 Description: Copier (6,504), Storage (1,200), Dishwasher (658)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Allocated from Management Co.			6,968	18
19					19
20					20
21	TOTAL		$	$ 6,968	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 156,406	$		$ 156,406	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			24,995			24,995	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			170,516	15,334		185,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				90,406		90,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Ancillaries-Veterans						241		241	13
14	TOTAL			$		$ 351,917	$ 105,981		$ 457,898	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Renaissance Care Center **#** 0040295 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ (406,560)	$ (248,873)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	2,574,298	2,574,298	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	118,551	169,251	6
7	Other Prepaid Expenses	7,998	7,998	7
8	Accounts Receivable (owners or related parties)	1,470,615	1,620,615	8
9	Other(specify): See Attached Schedule 17A	231	164,265	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,765,133	$ 4,287,554	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		281,277	13
14	Buildings, at Historical Cost		5,772,152	14
15	Leasehold Improvements, at Historical Cost	454,591	1,298,857	15
16	Equipment, at Historical Cost	715,009	1,177,045	16
17	Accumulated Depreciation (book methods)	(960,038)	(5,011,211)	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 (spe LTC Mgmt Stock	68,459	68,459	22
23	Other(specify): Loan Fees		93,436	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 278,021	$ 3,680,015	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,043,154	$ 7,967,569	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,010,019	$ 1,104,417	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	984,020	984,020	29
30	Accrued Salaries Payable	243,723	243,723	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,348	14,348	31
32	Accrued Real Estate Taxes(Sch.IX-B)		68,531	32
33	Accrued Interest Payable	1,887	38,098	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	40,994	40,994	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,294,991	$ 2,494,131	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,240,335	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Mortgage Premium		911,913	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,152,248	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,294,991	$ 15,646,379	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,748,163	$ (7,678,810)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,043,154	$ 7,967,569	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line Other Current Assets (specify):

Description	Operating	After Consolidation
TAXES ON DEPOSIT	231	231
REPLACEMENT RESERVE		103,819
ESCROW-REAL ESTATE TAX		37,100
ESCROW-MIP		10,781
ESCROW-INSURANCE		12,334
Total - Line 9	**231**	**164,265**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
DUE TO IDPA	39,110	39,110
DAY TRAINING	1,884	1,884
Total - Line 36	**40,994**	**40,994**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,940,379	1
2	Restatements (describe): Bad Debt Expense		2
3	See Attached Schedule 18A	(145,571)	3
4	Rounding	(6)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,794,802	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(46,639)	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)**	$ (46,639)	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)**	$ 1,748,163	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/16**

Schedule 18A

XVI. Statement of Changes in Equity
Line 2 Restatements

Description	Amount
Audit Take Back	51,304
Bad Debt Expense	(196,875)
Total	**(145,571)**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,402,060	1
2	Discounts and Allowances for all Levels	(53,445)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,348,615	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	89,557	6
7	Oxygen	15	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 89,572	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	2	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	178	19
20	Radiology and X-Ray	13	20
21	Other Medical Services	2,328	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,695	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,447,882	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,007,308	31
32	Health Care	3,594,992	32
33	General Administration	1,777,066	33
	B. Capital Expense		
34	Ownership	1,072,354	34
	C. Ancillary Expense		
35	Special Cost Centers	676,801	35
36	Provider Participation Fee	366,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,494,521	40
41	**Income before Income Taxes (line 30 minus line 40)****	(46,639)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (46,639)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,824,690	44
45	Private Pay - Net Inpatient Revenue	625,685	45
46	Medicare - Net Inpatient Revenue	1,326,279	46
47	Other-(specify) **Managed Care**	566,681	47
48	Other-(specify) **Pediatric/Exceptional Care**	4,005,280	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,348,615	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,176	$ 73,812	$ 33.92	1
2	Assistant Director of Nursing	1,908	2,080	60,019	28.86	2
3	Registered Nurses	22,019	24,460	641,671	26.23	3
4	Licensed Practical Nurses	26,080	27,297	630,512	23.10	4
5	CNAs & Orderlies	93,895	110,935	1,312,192	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,788	1,959	25,522	13.03	8
9	Activity Director	1,884	2,120	27,226	12.84	9
10	Activity Assistants	1,550	1,578	17,275	10.95	10
11	Social Service Workers	1,864	1,913	35,293	18.45	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,120	41,331	19.50	13
14	Head Cook	6,938	7,508	71,439	9.52	14
15	Cook Helpers/Assistants	5,881	6,121	59,900	9.79	15
16	Dishwashers					16
17	Maintenance Workers	3,329	3,527	75,757	21.48	17
18	Housekeepers	14,517	15,345	170,384	11.10	18
19	Laundry	5,052	5,302	56,115	10.58	19
20	Administrator	1,984	2,152	78,978	36.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,518	4,982	94,381	18.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,448	1,588	33,346	21.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,637	5,137	67,127	13.07	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	9,610	10,222	242,353	23.71	33
34	TOTAL (lines 1 - 33)	212,806	238,522	$ 3,814,633 *	$ 15.99	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	336	$ 18,847	L1,C3	35
36	Medical Director	Monthly	6,600	L9,C3	36
37	Medical Records Consultant	114	2,850	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	128	9,889	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	21	1,260	L10A,C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	68	2,808	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	667	$ 42,254		49

C. CONTRACT NURSES

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

Renaissance Care Center

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,860	4,144	110,571	26.68
Transportation	2,246	2,389	38,533	16.13
Director of Residential Services	1,528	1,561	42,321	27.11
Marketing	1,976	2,128	50,928	23.93
TOTAL	9,610	10,222	242,353	

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Martha Jones	Administrator	0	$ 78,978
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,978

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 525,084
TOTAL (agree to Schedule V, line 17, col. 3)	$ 525,084
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 15,603
E-Health Data Solutions	Data Processing	974
PayChex	Payroll Service	31,002
SpyGlass Group	Cost Reduction Services	3,829
On Shift	Data Processing	1,481
Ability Network	Data Processing	2,991
Personnel Planners	Unemployment Consulting	12,200
Wescom Solutions Inc	Data Processing	38,885
See Attached Legal Schedule	Legal Fees	4,611
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 111,576

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,784
Unemployment Compensation Insurance	46,622
FICA Taxes	284,575
Employee Health Insurance	205,145
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	15,994
Pension Plan Contribution	13,940
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,060

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	3,166
Health Care Worker Background Check	
(Indicate # of checks performed 218)	2,179
Patient Background Checks	
IHCA	12,350
Dues & Subscriptions	163
Licenses & Permits	1,694
Allocated from Management Co.	1,767
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,309

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	23,842
Allocated from Management Co.	10,615
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,457

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/16 Ending: 12/31/16

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? **Yes**
If YES, give association name and amount. **12,350 IHCA**

(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. $ **7,305** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **366,000**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees