		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 1/1/2020 to 12/31/2020 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 326, Plainfield, IL 60544-0326
(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: 1/1/2020 Ending: 12/31/2020

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			2,331	2,331	8
9	SNF/PED	24,677	80		24,757	9
10	ICF	14,360	2,477		16,837	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,037	2,557	2,331	43,925	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.17%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2,067

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: 12/31/20 Fiscal Year: 12/31/20

* 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: 1/1/2020 Ending: 12/31/2020

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	201,371	18,186	18,723	238,280		238,280		238,280			1
2	Food Purchase		269,797		269,797		269,797		269,797			2
3	Housekeeping	157,550	57,878		215,428		215,428		215,428			3
4	Laundry	91,394	31,742		123,136		123,136		123,136			4
5	Heat and Other Utilities			138,719	138,719		138,719	3,029	141,748			5
6	Maintenance	90,918	75,059	64,850	230,827		230,827	1,390	232,217			6
7	Other (specify):* Waste Removal			9,161	9,161		9,161		9,161			7
8	TOTAL General Services	541,233	452,662	231,453	1,225,348		1,225,348	4,419	1,229,767			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	3,431,661	507,675	11,055	3,950,391		3,950,391	170,336	4,120,727			10
10a	Therapy											10a
11	Activities	51,819		8,019	59,838		59,838		59,838			11
12	Social Services	244,892		3,692	248,584		248,584		248,584			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co Benefits Alloc							32,608	32,608			15
16	TOTAL Health Care and Programs	3,728,372	507,675	28,766	4,264,813		4,264,813	202,944	4,467,757			16
	C. General Administration											
17	Administrative	86,906		620,594	707,500		707,500	(457,843)	249,657			17
18	Directors Fees											18
19	Professional Services			162,432	162,432		162,432	21,770	184,202			19
20	Dues, Fees, Subscriptions & Promotions			35,537	35,537		35,537	(3,662)	31,875			20
21	Clerical & General Office Expenses	150,909	6,557	61,955	219,421		219,421	234,566	453,987			21
22	Employee Benefits & Payroll Taxes			576,560	576,560		576,560		576,560			22
23	Inservice Training & Education			13,024	13,024		13,024		13,024			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			11,596	11,596		11,596	9,735	21,331			25
26	Insurance-Prop.Liab.Malpractice			207,567	207,567		207,567	3,601	211,168			26
27	Other (specify):* Mgmt Co Benefits Alloc							72,739	72,739			27
28	TOTAL General Administration	237,815	6,557	1,689,265	1,933,637		1,933,637	(119,094)	1,814,543			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,507,420	966,894	1,949,484	7,423,798		7,423,798	88,269	7,512,067			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: 1/1/2020 Ending: 12/31/2020

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			38,036	38,036		38,036	266,956	304,992			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,640	14,640		14,640	368,982	383,622			32
33	Real Estate Taxes							72,274	72,274			33
34	Rent-Facility & Grounds			909,600	909,600		909,600	(894,190)	15,410			34
35	Rent-Equipment & Vehicles			22,973	22,973		22,973	555	23,528			35
36	Other (specify):*							57,589	57,589			36
37	**TOTAL Ownership**			985,249	985,249		985,249	(127,834)	857,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	969	72,089	232,141	305,199		305,199		305,199			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			347,006	347,006		347,006		347,006			42
43	Other (specify):* **Disallowed Costs**	52,543	1,769	166,832	221,144		221,144	(205,375)	15,769			43
44	**TOTAL Special Cost Centers**	53,512	73,858	745,979	873,349		873,349	(205,375)	667,974			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,560,932	1,040,752	3,680,712	9,282,396		9,282,396	(244,940)	9,037,456			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 1/1/2020
Period End 12/31/2020

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/Expenses			15,769	15,769		15,769		15,769			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses	52,543	1,769	151,063	205,375		205,375	(205,375)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	52,543	1,769	166,832	221,144	0	221,144	(205,375)	15,769			

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(24,063)	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	35,922	30		9
10	Interest and Other Investment Income	(137)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	43		13
14	Non-Care Related Interest	(9,527)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,306)	20		17
18	Fines and Penalties	(26,721)	43		18
19	Entertainment				19
20	Contributions	(500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(93,011)	43		24
25	Fund Raising, Advertising and Promotional	(7,792)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(372)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(225,109)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (352,989)		$	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)	108,049		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 108,049		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (244,940)		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: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Wages	$ (52,543)	43	1
2	Marketer Car Lease	(4,860)	35	2
3	Offset Miscellaneous Income Against Expense	(1,377)	21	3
4	Disallow PAC Dues	(3,342)	20	4
5	Disallow Management Fees with No Cost	(153,487)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12	Building Co.			12
13	Accounting Fees	(9,500)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(225,109)		49

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	19	Professional Fees		Renaissance Care Center Property LLC	100.00%	9,500	$ 9,500	1
2	V	30	Depreciation		Renaissance Care Center Property LLC	100.00%	231,034	231,034	2
3	V	32	Interest	38	Renaissance Care Center Property LLC	100.00%	365,875	365,837	3
4	V	32	Amortization Expense		Renaissance Care Center Property LLC	100.00%	2,803	2,803	4
5	V	33	Real Estate Taxes		Renaissance Care Center Property LLC	100.00%	72,274	72,274	5
6	V	34	Rent-Facility & Grounds	909,600	Renaissance Care Center Property LLC	100.00%		(909,600)	6
7	V	36	Mortgage Insurance		Renaissance Care Center Property LLC	100.00%	57,589	57,589	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 909,638			$ 739,075	$ * (170,563)	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: 1/1/2020 Ending: 12/31/2020

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%	$ 3,029	$ 3,029	15
16	V	6	Maintenance		Certified Health Management, Inc.	100.00%	1,390	1,390	16
17	V	10	Nursing and Medical Records		Certified Health Management, Inc.	100.00%	170,336	170,336	17
18	V	15	Emp Benefit Alloc-Healthcare		Certified Health Management, Inc.	100.00%	32,608	32,608	18
19	V	17	Administrative	467,107	Certified Health Management, Inc.	100.00%	162,751	(304,356)	19
20	V	19	Professional Services		Certified Health Management, Inc.	100.00%	21,770	21,770	20
21	V	20	Dues, Fees, Subs & Promo		Certified Health Management, Inc.	100.00%	986	986	21
22	V	21	Clerical & Gen Office Expenses		Certified Health Management, Inc.	100.00%	235,943	235,943	22
23	V	25	Other Admin Staff Transportation		Certified Health Management, Inc.	100.00%	9,735	9,735	23
24	V	26	Ins.-Prop, Liab, Malpractice		Certified Health Management, Inc.	100.00%	3,601	3,601	24
25	V	27	Emp Benefit Alloc-Gen Admin		Certified Health Management, Inc.	100.00%	72,739	72,739	25
26	V	32	Interest Expense		Certified Health Management, Inc.	100.00%	10,006	10,006	26
27	V	34	Rent-Facility & Grounds		Certified Health Management, Inc.	100.00%	15,410	15,410	27
28	V	35	Rent-Equipment & Vehicle		Certified Health Management, Inc.	100.00%	5,415	5,415	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			$ 467,107			$ 745,719	$ * 278,612	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: 1/1/2020 Ending: 12/31/2020

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%	Danville Care Center	Danville	Center Property LLC			2
3	Laurence Zung	3.506%			Certified Health	Skokie	Management	3
4	Irene Sandler	2.768%			Management, Inc.			4
5	Ira Shyman	1.845%			RCC Consulting LLC	Canton	Management	5
6	Jerrold Noble	1.845%						6
7	Jennifer Chow	1.845%						7
8	Julie Brum	1.845%						8
9	Sheldon Ashman	0.254%						9
10	Sherri Gross	0.254%						10
11	Roberta Nussbaum	0.254%						11
12	Gary Ashman	0.254%						12
13	Eve Ashman	0.829%						13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Bradley Alter	Owner	Administration	22.826%	See Att Sch 7A	29.64	59.28	Alloc. Salary	109,654	L17, C7	1
2	Zev Geller	Relative	Clerical	0.00	See Att Sch 7A	23.71	59.28	Alloc. Salary	14,945	L21, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 124,599		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: 1/1/2020 Ending: 2/31/2020

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	72,909	3	$ 5,110	$	43,215	$ 3,029	1
2	6	Maintenance	Census Days	72,909	3	2,345		43,215	1,390	2
3	10	Nursing and Medical Records	Census Days	72,909	3	287,378	287,378	43,215	170,336	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	72,909	3	55,013		43,215	32,608	4
5	17	Administrative	Census Days	72,909	3	274,581	274,581	43,215	162,751	5
6	19	Professional Services	Census Days	72,909	3	36,728		43,215	21,770	6
7	20	Dues, Fees, Subs & Promo	Census Days	72,909	3	1,664		43,215	986	7
8	21	Clerical & Gen Office Expenses	Census Days	72,909	3	398,065	366,479	43,215	235,943	8
9	25	Other Admin Staff Transportatior	Census Days	72,909	3	16,424		43,215	9,735	9
10	26	Ins.-Prop, Liab, Malpractice	Census Days	72,909	3	6,075		43,215	3,601	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	72,909	3	122,720		43,215	72,739	11
12	32	Interest Expense	Census Days	72,909	3	16,882		43,215	10,006	12
13	34	Rent-Facility & Grounds	Census Days	72,909	3	26,000		43,215	15,410	13
14	35	Rent-Equipment & Vehicle	Census Days	72,909	3	9,136		43,215	5,415	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,258,121	$ 928,438		$ 745,719	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 11,418,616		0.0500	$ 365,875	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit						0.0450	5,113	6
7												7
8												8
9	TOTAL Facility Related						$	$ 11,418,616			$ 370,988	9
	B. Non-Facility Related*											
10												10
11								Allocated from Management Co.			10,006	11
12								Offset Interest Income			(175)	12
13								Amortization Expense			2,803	13
14	TOTAL Non-Facility Related						$	$			$ 12,634	14
15	TOTALS (line 9+line14)						$	$ 11,418,616			$ 383,622	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 57,589 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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 69,986	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.)	2019	$ 70,260	2
3. Under or (over) accrual (line 2 minus line 1).		$ 274	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,000	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.		$ 72,274	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	66,534	8
	2016	70,365	9
	2017	68,232	10
	2018	68,614	11
	2019	70,260	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance Care Center COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0040295

CONTACT PERSON REGARDING THIS REPORT Brad Alter

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 2019 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 2019.

	(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	$ 70,259.94	$ 70,259.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,259.94	$ 70,259.94

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/2020 Ending: 12/31/2020

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: 1/1/2020 Ending: 12/31/2020

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	$ 3,943,806	4
5				2010	534,152		27.5	19,424	19,424	213,664	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			23,578	12
13	Various			1998	47,834		20			47,834	13
14	Various			1999	21,162		20			21,162	14
15	Various			2000	9,146		20	192	192	9,146	15
16	Various			2001	48,446		20	2,422	2,422	47,233	16
17	Various			2002	2,252		20	113	113	2,085	17
18	Various			2003	16,990		20	850	850	14,869	18
19	Various			2004	4,707		20	235	235	3,882	19
20	Various			2005	30,220		20	1,511	1,511	23,546	20
21	Various			2006	52,027		20	2,601	2,601	37,718	21
22	Various			2007	5,890		20	295	295	4,076	22
23	Various			2008	23,192		20	578	578	23,192	23
24	Various			2010	26,646		20	1,332	1,332	26,607	24
25	Various			2011	37,596		20	1,064	1,064	37,596	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: 1/1/2020 Ending: 12/31/2020

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	$ 2,804	37
38	Thru Wall A/C Unit	2012	2,695		20	135	135	2,023	38
39	Video Monitor System	2012	16,353		20	818	818	16,082	39
40	Vinyl Flooring, Cove Base - Pt Room	2012	10,579		20	529	529	9,521	40
41	Menards - Sink, Faucet, Granite - Therapy Room - 100 Wing	2012	2,657		20	133	133	2,436	41
42	Walls, Flooring, Millwork, Handrails-Lobby,Activity,Concierge,N	2012	2,500		20	125	125	1,031	42
43	Repair Sewer Line	2012	4,314		20	216	216	1,799	43
44	Sealcoating	2012	6,000		20	300	300	2,475	44
45	Replace 2 Sets Of Doors - Facility Entry - Front Of Building	2012	5,372		20	269	269	2,173	45
46	Fluorescent Sign Display	2013	7,528		20	376	376	3,009	46
47	Electric Wiring/Breakers/Directional Boring	2013	4,305		20	215	215	1,541	47
48	Water Heater	2013	11,620		20	581	581	4,115	48
49	Duplex Outlets And Hallway Light Rework	2013	3,350		20	168	168	1,245	49
50	Removable Signage	2013	3,843		20	192	192	3,202	50
51	Roof Wall Area Repair	2013	2,926		20	146	146	1,096	51
52	New Alarm/Camera/Monitoring System	2014	3,259		20	163	163	2,119	52
53	Firewall Upgrade	2014	2,500		20	125	125	823	53
54	Roof Over Front Entrance	2016	10,180		20	509	509	2,545	54
55	Roof Repairs-Kitchen/Dining/Medical Records	2016	2,780		20	139	139	695	55
56	Repair Water Damage in Ceiling/Lights-Upstairs Offices	2017	8,599		20	430	430	1,720	56
57	Seal and Stripe Parking Lot	2017	5,000		20	250	250	1,000	57
58	Installed New Water Heater	2017	3,525		20	176	176	704	58
59	Generator Repair	2017	11,066		20	553	553	2,212	59
60	Walk-In Freezer Repair	2017	4,438		20	222	222	888	60
61	PTAC Units (4)	2018	2,749		20	137	137	411	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,296,835	$		$ 228,327	$ 228,327	$ 4,577,927	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: 1/1/2020 Ending: 12/31/2020

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		$ 6,296,835	$		$ 228,327	$ 228,327	$ 4,577,927	1
2	Leasehold Improvements (Real Estate Entity):								2
3	Fire Protection Line	2009	15,714		20	786	786	9,518	3
4	Flooring - Econocare	2009	18,657		20	933	933	18,969	4
5	Windows	2009	96,772		20	4,839	4,839	68,550	5
6	Tile Work	2009	4,000		20	200	200	2,867	6
7	Blacktop	2009	30,000		20	1,500	1,500	18,333	7
8	Masonry	2009	17,860		20	893	893	9,823	8
9	Fire Protection	2010	105,000		20	5,250	5,250	71,750	9
10	Wallcovering, ceramic tile, carpet, laminate nurses station	2010	84,876		20	4,244	4,244	82,048	10
11	ALTA Survey (Engineer)	2010	2,659		20	133	133	1,817	11
12	Window Treatments	2010	6,379		20	319	319	4,359	12
13	Installation of Hickory colored GAF Architectural Shingles	2010	16,650		20	833	833	9,162	13
14	Installation of 40 circuit extension plugmold strips in 20 rooms	2011	8,500		20	425	425	5,100	14
15	Walls,ceiling tile, flooring,millwork,lighting,cabinetry,handrails,w	2012	248,972		20	12,449	12,449	112,041	15
16	Carpet Tile - 100 Wing Resident Rooms	2013	6,409		20	320	320	2,560	16
17	Oak Cabinets - 100 Wing Remodeling	2013	6,210		20	311	311	2,488	17
18	Decorative Cornices - 100 Wing Resident Rooms	2013	2,859		20	143	143	1,144	18
19	Ceramic Floor Tiles	2013	4,415		20	221	221	1,700	19
20	Roofing Membrane Repairs	2014	9,500		20	475	475	2,850	20
21	Doors	2015	6,060		20	303	303	1,818	21
22	Wander Guard	2015	2,557		20	128	128	768	22
23	Sidewalk & Gazebo	2015	17,300		20	865	865	5,190	23
24	East Wing Shower Remodel	2015	7,500		20	375	375	2,000	24
25	West Wing Shower Remodel	2015	8,000		20	400	400	2,133	25
26	Install Rooftop Unit	2015	5,870		20	294	294	1,617	26
27	West Wing Remodeling	2015	8,000		20	400	400	2,067	27
28	East Wing Remodeling	2015	7,500		20	375	375	1,938	28
29	East Wing Shower Remodeling	2015	15,752		20	788	788	4,006	29
30	West Wing Shower Remodel-Frame Walls, Insulate Attic, Plumbing,								30
31	Electric, Exhaust, Painting	2016	17,157		20	858	858	4,472	31
32	Install New Water Heater	2019	13,500		20	675	675	1,013	32
33	Install Two Rooftop AC Units	2019	13,840		20	692	692	1,038	33
34	TOTAL (lines 1 thru 33)		$ 7,105,303	$		$ 268,754	$ 268,754	$ 5,031,066	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: 1/1/2020 Ending: 12/31/2020

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 12B, Carried Forward		$ 7,105,303	$		$ 268,754	$ 268,754	$ 5,031,066	1
2	200 Wing Remodel - Demo of walls, install ceiling tiles	2019	184,034		20	9,202	9,202	13,803	2
3	Light fixtures, Flooring, Cove Base, Handrails								3
4	Blacktop Resurfacing	2019	7,895		20	395	395	592	4
5	Storage Garage	2019	54,818		20	2,741	2,741	4,099	5
6	Re-Pipe Second Floor Sprinkler	2020	2,751		20	69	69	69	6
7	Upstairs Office Remodel-Windows/Walls/Electric/Level Floor/Pai	2020	56,600		20	1,415	1,415	1,415	7
8	Install New Roof Top AC Unit/HVAC Improvements	2020	10,550		20	264	264	264	8
9	New Roof	2020	222,275		20	5,557	5,557	5,557	9
10	Replace Nurse Call System-300 Wing	2020	20,963		20	524	524	524	10
11	Install New Generator	2020	54,353		20	1,359	1,359	1,359	11
12	Parking Lot Repairs	2020	4,745		20	119	119	119	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	Allocated from Certified Health Management	1997	55,846		20			55,846	28
29	Allocated from Certified Health Management	2014	15,701		20	785	785	5,889	29
30									30
31									31
32	Financial Statement Depreciation			38,036			(38,036)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,795,834	$ 38,036		$ 291,184	$ 253,148	$ 5,120,602	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: 1/1/2020 Ending: 12/31/2020

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	$ 22,497	$	$ 2,250	$ 2,250	10 yrs	$ 3,375	71
72	Current Year Purchases	13,508		675	675	10 yrs	675	72
73	Fully Depreciated Assets	1,154,473					1,154,473	73
74								74
75	TOTALS	$ 1,190,478	$	$ 2,925	$ 2,925		$ 1,158,523	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	Patient Transportation	2019 Dodge Caravan	2020	$ 37,964	$	$ 3,796	$ 3,796	5	$ 3,796	76
77	Staff	2013 VW Passat	2018	9,178		1,836	1,836	5	4,590	77
78	Patient Transportation	2011 Ford Van	2018	26,254		5,251	5,251	5	13,127	78
79										79
80	TOTALS			$ 73,396	$	$ 10,883	$ 10,883		$ 21,513	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)	$ 9,340,985	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,036	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,992	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 266,956	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,300,638	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	N/A	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.				15,410			5
6								6
7	TOTAL				$ 15,410 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 7,576 Description: See Attached Schedule 14A
(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	Administrative	Honda CRV	$ 394	$ 394	17
18	Administrative	Subaru Legacy	440	5,283	18
19	Administrative	Subaru Legacy	405	4,860	19
20	Allocated from Management Co.			5,415	20
21	TOTAL		$ 1,239	$ 15,952	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: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	3,623
Dishwasher	236
Storage	1,800
Misc	1,917
Total - Line 16	**7,576**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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	$		$ 80,486	$		$ 80,486	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			47,840			47,840	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			103,815	337		104,152	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				71,752		71,752	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy		16	969				16	969	12
13	Other (specify):									13
14	TOTAL			$ 969		$ 232,141	$ 72,089	16	$ 305,199	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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,387,607	$ 1,565,339	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 275,000)	1,330,325	1,330,325	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,229	138,458	6
7	Other Prepaid Expenses	65,589	65,589	7
8	Accounts Receivable (owners or related parties)	1,120,692	1,120,692	8
9	Other(specify): See Attached Schedule 17A	231	205,260	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,995,673	$ 4,425,663	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	837,623	2,023,682	15
16	Equipment, at Historical Cost	744,798	1,263,874	16
17	Accumulated Depreciation (book methods)	(1,033,705)	(6,300,638)	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): Loan Fees		82,224	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 548,716	$ 3,122,571	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,544,389	$ 7,548,234	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 587,107	$ 627,529	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	205,742	205,742	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,092	16,092	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,000	32
33	Accrued Interest Payable		33,780	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	109,615	109,615	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 918,556	$ 1,064,758	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,418,616	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Mortgage Premium		735,149	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,153,765	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 918,556	$ 13,218,523	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,625,833	$ (5,670,289)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,544,389	$ 7,548,234	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/2020**

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
TAXES ON DEPOSIT	231	231
REPLACEMENT RESERVE		121,177
ESCROW-REAL ESTATE TAX		31,800
ESCROW-MIP		32,697
ESCROW-INSURANCE		19,355
Total - Line 23	**231**	**205,260**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
DUE TO IDPA	108,500	108,500
DEFERRED RENT		
PATIENT SECURITY DEPOSIT	3,000	3,000
Day Training	(1,885)	(1,885)
Total - Line 36	**109,615**	**109,615**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,658,449	1
2	Restatements (describe):		2
3	**Prior Period Adj-Write off of Intercompany Loan**	(2,110,615)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 547,834	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,997,999	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	(920,000)	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)**	$ 3,077,999	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)**	$ 3,625,833	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 11,420,213	1
2	Discounts and Allowances for all Levels	(6,512)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,413,701	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	22,648	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 22,648	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	839,721	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	22,615	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(1)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 862,335	23
	D. Non-Operating Revenue		
24	Contributions	2,373	24
25	Interest and Other Investment Income***	137	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,510	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,377	28
28a	See Attached Schedule 19A	977,824	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 979,201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,280,395	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,225,348	31
32	Health Care	4,264,813	32
33	General Administration	1,933,637	33
	B. Capital Expense		
34	Ownership	985,249	34
	C. Ancillary Expense		
35	Special Cost Centers	526,343	35
36	Provider Participation Fee	347,006	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,282,396	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,997,999	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,997,999	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,507,238	44
45	Private Pay - Net Inpatient Revenue	586,455	45
46	Medicare - Net Inpatient Revenue	1,228,482	46
47	Other-(specify) Managed Care	91,526	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,413,701	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: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/2020**

Schedule 19A

XVII. Income Statement
Line 28a Other Income

Rental Description	Amount
Forgiveness of Debt	893,995
Prior Year Over Accrual	81,329
Gain on Sale of Asset	2,500
Total - Line 16	**977,824**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	3,706	4,160	$ 111,925	$ 26.91	1
2	Assistant Director of Nursing	1,908	2,080	75,107	36.11	2
3	Registered Nurses	26,773	28,947	876,488	30.28	3
4	Licensed Practical Nurses	21,525	23,578	597,861	25.36	4
5	CNAs & Orderlies	112,569	121,418	1,673,290	13.78	5
6	CNA Trainees					6
7	Licensed Therapist	16	16	969	60.56	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,817	5,001	51,819	10.36	10
11	Social Service Workers	5,596	6,272	180,384	28.76	11
12	Dietician					12
13	Food Service Supervisor	1,844	2,080	47,221	22.70	13
14	Head Cook	4,000	4,240	52,362	12.35	14
15	Cook Helpers/Assistants	9,548	10,132	101,788	10.05	15
16	Dishwashers					16
17	Maintenance Workers	4,317	4,579	90,918	19.86	17
18	Housekeepers	11,314	12,113	157,550	13.01	18
19	Laundry	8,356	8,951	91,394	10.21	19
20	Administrator	1,814	2,080	86,906	41.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,276	11,175	150,909	13.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,812	2,027	25,895	12.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	7,706	8,461	188,146	22.24	33
34	TOTAL (lines 1 - 33)	237,897	257,310	$ 4,560,932 *	$ 17.73	34

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	Monthly	$ 18,723	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	Quarterly	2,223	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,832	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,692	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,470		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Renaissance Care Center

Period Beginning **1/1/2020**
Period End **12/31/2020**

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		1,894	2,080	71,095	34.18
Transportation		3,981	4,411	64,508	14.62
Marketing		1,831	1,970	52,543	26.67
	TOTAL	7,706	8,461	188,146	

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Lockwood	Administrator	0	$ 86,906
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,906

B. Administrative - Other

Description	Amount
Management Fees-See Page 6A, Eliminated on P 3, C 7	$ 467,107
RCC Consulting LLC-Disallowed on P3 Column 7	153,487
TOTAL (agree to Schedule V, line 17, col. 3)	$ 620,594
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Service	$ 27,716
Templin Healthcare Accounting	Accounting Service	14,546
Dugan & Lopatka CPA's PC	Accounting Service	6,333
Goldleaf Partners	Accounting Service	1,812
Paycor	Payroll Service	28,680
MPRO	Peer Review Consultants	1,279
Availity/Real Med	Data Processing	5,137
Personnel Planners	Unemployment Consulting	4,936
Wescom Solutions Inc	Data Processing	35,861
Terrill Consulting	Billing Consultant	16,107
See Attached Legal Schedule	Legal Fees	14,190
See Attached Schedule 21A		5,835
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 162,432

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,509
Unemployment Compensation Insurance	80,127
FICA Taxes	341,857
Employee Health Insurance	38,333
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	9,624
Pension Plan Contribution	14,110
TOTAL (agree to Schedule V, line 22, col.8)	$ 576,560

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	17,679
Health Care Worker Background Check	
(Indicate # of checks performed 63)	
Patient Background Checks	630
IHCA	12,160
Dues & Subscriptions	2,501
Licenses & Permits	577
Allocated from Management Co.	986
Less IHCA PAC Dues	(3,342)
Less: Public Relations Expense	(1,306)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,875

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	None
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Renaissance Care Center**
IDPH License ID Number: **0040295**
Fiscal Year End: **12/31/2020**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Shoshana Tarshish	Billing Consultant	2,500
2401 Incorporated	Architect Consulting	3,335
Total		**5,835**

Facility Name & ID Number Renaissance Care Center # 0040295 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. **12,160 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,807** 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. $ **347,006**
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? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 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 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.