

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0042085</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Renaissance At South Shore</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2425 East 71St St.</u> <u>Chicago</u> <u>60616</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 721-5000</u> Fax # <u>(773) 721-6850</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
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	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																								
Date of Initial License for Current Owners: <u>10/23/98</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore

0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			16,634	16,634	8
9	SNF/PED					9
10	ICF	62,553	1,973	2,755	67,281	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,553	1,973	19,389	83,915	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.70%

D. How many bed-hold days during this year were paid by the Department? 7 (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

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 10/23/1998

J. Was the facility purchased or leased after January 1, 1978? YES X Date 10/23/1998 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 248 and days of care provided 15,254

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	430,443	68,528	16,480	515,451		515,451		515,451			1
2	Food Purchase		467,350		467,350	(25,550)	441,800	(110)	441,690			2
3	Housekeeping	251,084	47,232	65	298,381		298,381		298,381			3
4	Laundry	150,195	34,645		184,840		184,840		184,840			4
5	Heat and Other Utilities			217,408	217,408		217,408	(5,657)	211,751			5
6	Maintenance	111,904	89,335	236,744	437,983		437,983	9,598	447,581			6
7	Other (specify):*											7
8	TOTAL General Services	943,626	707,090	470,697	2,121,413	(25,550)	2,095,863	3,831	2,099,694			8
	B. Health Care and Programs											
9	Medical Director			82,300	82,300		82,300		82,300			9
10	Nursing and Medical Records	4,843,526	668,359	22,724	5,534,609		5,534,609	(16,399)	5,518,210			10
10a	Therapy	178,797		885	179,682		179,682		179,682			10a
11	Activities	217,764	39,896		257,660		257,660		257,660			11
12	Social Services	174,930		2,050	176,980		176,980		176,980			12
13	CNA Training											13
14	Program Transportation			4,065	4,065		4,065		4,065			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,415,017	708,255	112,024	6,235,296		6,235,296	(16,399)	6,218,897			16
	C. General Administration											
17	Administrative	234,086		1,100,943	1,335,029		1,335,029	(1,075,689)	259,340			17
18	Directors Fees											18
19	Professional Services			186,473	186,473	(1,105)	185,368	(25,543)	159,825			19
20	Dues, Fees, Subscriptions & Promotions			133,327	133,327		133,327	(57,535)	75,792			20
21	Clerical & General Office Expenses	290,375	64,987	592,156	947,518		947,518	(329,644)	617,874			21
22	Employee Benefits & Payroll Taxes			1,462,916	1,462,916	25,550	1,488,466		1,488,466			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,076	17,076		17,076	(4,584)	12,492			24
25	Other Admin. Staff Transportation			4,385	4,385		4,385	1,035	5,420			25
26	Insurance-Prop.Liab.Malpractice			864,654	864,654		864,654	795	865,449			26
27	Other (specify):*							56,309	56,309			27
28	TOTAL General Administration	524,461	64,987	4,361,930	4,951,378	24,445	4,975,823	(1,434,856)	3,540,967			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,883,104	1,480,332	4,944,651	13,308,087	(1,105)	13,306,982	(1,447,425)	11,859,557			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			264,918	264,918		264,918	(9,824)	255,094			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							642	642			32
33	Real Estate Taxes			483,470	483,470	1,105	484,575	8,569	493,144			33
34	Rent-Facility & Grounds			1,904,920	1,904,920		1,904,920	451	1,905,371			34
35	Rent-Equipment & Vehicles			27,082	27,082		27,082	3,538	30,620			35
36	Other (specify):*											36
37	TOTAL Ownership			2,680,390	2,680,390	1,105	2,681,495	3,376	2,684,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,062	689,073	1,091,138	1,786,273		1,786,273		1,786,273			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			447,241	447,241		447,241		447,241			42
43	Other (specify):*	244,383		244,889	489,272		489,272	(489,272)				43
44	TOTAL Special Cost Centers	250,445	689,073	1,783,268	2,722,786		2,722,786	(489,272)	2,233,514			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,133,549	2,169,405	9,408,309	18,711,263	0	18,711,263	(1,933,320)	16,777,943			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	(8,210)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,136)	30		9
10	Interest and Other Investment Income	(2,258)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,030)	24		19
20	Contributions	(23,623)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(490,797)	21		24
25	Fund Raising, Advertising and Promotional	(29,076)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,090)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(213)	20		28
29	Other-Attach Schedule	(602,046)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,181,589)		\$	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)	(751,732)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (751,732)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,933,320)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Patient Needs	\$ (10,234)	10	1
2	Patient Clothing	(14,735)	10	2
3	Bank Charges	(21,521)	21	3
4	Vending income	(185)	21	4
5	Jury Duty Income	(69)	21	5
6	Income from copies	(1,328)	21	6
7	Non Allowable Fee	(3,000)	21	7
8	Non-allowable and prior year legal	(53,915)	19	8
9	COPE Dues	(5,856)	20	9
10	Capitalized R&M	(8,410)	06	10
11	Non Reimbursable Salary	(74,168)	43	11
12	Marketing Wages	(42,398)	43	12
13	Non-Allowable Seminar	(1,087)	24	13
14	Additonal R&M	7,566	06	14
15	Non-Allowable Admin. Fees	(244,889)	43	15
16	Guest Relations	(56,059)	43	16
17	Community Relations	(71,758)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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31				31
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33				33
34				34
35				35
36				36
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(602,046)		49

Renaissance At South Shore

	ID#	0042085
Report Period Beginning:		01/01/11
Ending:		12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
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83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

Summary B

12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,553	\$ 2,553	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	10,149	10,149	16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	15,995	15,995	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	27,909	27,909	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,198	1,198	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	169,918	169,918	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	306	306	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	712	712	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	795	795	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	53,819	53,819	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	9,178	9,178	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,748	2,748	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	8,569	8,569	27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	451	451	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,538	3,538	29
30	V								30
31	V								31
32	V								32
33	V	17	Management Fees	970,969				(970,969)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 970,969			\$ 307,836	\$ * (663,133)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 293	\$ 293	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	8,570	8,570	16
17	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			17
18	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	35	35	18
19	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	16,609	16,609	19
20	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,119	1,119	20
21	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	227	227	21
22	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	323	323	22
23	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	86	86	23
24	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	999	999	24
25	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	134	134	25
26	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	153	153	26
27	V								27
28	V								28
29	V								29
30	V	17	ADMINISTRATIVE FEES	64,974	CLINICAL CONSULTING SERVICES, LLC	100.00%		(64,974)	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			\$ 64,974			\$ 28,549	\$ * (36,425)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 9,259	\$ 9,259	15
16	V	19	PROFESSIONAL FEES				463	463	16
17	V	21	OFFICE				1,700	1,700	17
18	V	27	EMPLOYEE BENEFITS				1,405	1,405	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	65,000				(65,000)	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			\$ 65,000			\$ 12,827	\$ * (52,173)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workmans Comp	\$ 318,575	Diamond Insurance	100.00%	\$ 318,575	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 318,575			\$ 318,575	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	4.841%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH/ CHICAGO		CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	1
2	BERNARD HOLLANDER FAMILY TRUST	24.697%	CALIFORNIA GARDENS CORP.	CHICAGO	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	2
3	DAVID SCHECHTER	1.211%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	DBD REHABILITAION SERV.	CHICAGO	PSYCHIATRIC SERVICES	3
4	EVAN MICHAEL STERN 2005 TRUST	0.889%	CLARIDGE IMPERIAL, LTD.	CHICAGO	JEM REHABILITATION SERV.	CHICAGO	PSYCHIATRIC SERVICES	4
5	JONATHAN AARON	1.482%	FOREST VILLA NURSING & REHABILITATION CENTER, L.L.C.	NILES	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	5
6	JONATHAN BRYAN STERN TRUST 2001	0.889%	JACKSON CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	6
7	MARSHALL A. MAUER	6.174%	MONROE CORP.	CHICAGO	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	7
8	MAURICE I. AARON	4.693%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	8
9	ORIOLE TRUST	4.890%	THE RENAISSANCE AT HILLSIDE, INC.	HILLSIDE	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING / MANAGE	9
10	RAJCHENBACH FAMILY TRUST	24.697%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	DRAKE LOUIS ENTERPRISE, LL	LINCOLNWOOD	MANAGEMENT CO.	10
11	ROBERT HARTMAN FAMILY TRUST	19.807%	RENAISSANCE EAST	MESA, ARIZONA	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP	11
12	SUSAN L. STERN	4.841%	RENAISSANCE PARK SOUTH, LLC	CHICAGO				12
13	TODD ANDREW STERN TRUST 2001	0.889%	RENAISSANCE VILLAGE AL	MESA, ARIZONA				13
14			RENAISSANCE VILLAGE IL	MESA, ARIZONA				14
15			RENAISSANCE WEST	MESA, ARIZONA				15
16			CLAREMONT-HANOVER PARK	HANOVER PARK				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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0.00%	See Attached	0.83	2.08%		\$		1
2											2
3	Jack Rajchenbach	Relative	Administrative	0.00%	See Attached	5	7.69%	Alloc. Salary	9,259	17-07	3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only										7
8	amounts anticipated to be considered allowable by the Il. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,259		13

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,283,340	16	\$ 36,192	\$	90,520	\$ 2,553	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,283,340	16	143,887		90,520	10,149	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,283,340	16	226,766	211,441	90,520	15,995	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	16	395,673		90,520	27,909	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,283,340	16	16,986		90,520	1,198	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,283,340	16	2,408,992	(706,320)	90,520	169,918	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,283,340	16	4,332		90,520	306	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,283,340	16	10,088		90,520	712	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,283,340	16	11,273		90,520	795	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,283,340	16	763,008		90,520	53,819	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	16	130,120		90,520	9,178	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,283,340	16	38,953		90,520	2,748	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,283,340	16	121,491		90,520	8,569	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,283,340	16	6,400		90,520	451	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,283,340	16	50,154		90,520	3,538	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,364,315	\$		\$ 307,836	25

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CLINICAL CONSULTING SERVICES, LLC
Street Address 7257 N. LINCOLN AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (847) 933-2600
Fax Number (847) 933-2601

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MINOR EQUIPMENT	AVAIL. CENSUS DAYS	1,283,340	17	\$ 4,147	\$	90,520	\$ 293	1
2	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,283,340	17	121,500	121,500	90,520	8,570	2
3	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	17			90,520		3
4	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,283,340	17	500		90,520	35	4
5	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,283,340	17	235,467	235,467	90,520	16,609	5
6	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	15,872		90,520	1,119	6
7	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,283,340	17	3,225		90,520	227	7
8	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	4,586		90,520	323	8
9	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,283,340	17	1,222		90,520	86	9
10	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,283,340	17	14,168		90,520	999	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	17	1,896		90,520	134	11
12	32	INTEREST	AVAIL. CENSUS DAYS	1,283,340	17	2,164		90,520	153	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 404,746	\$ 356,967		\$ 28,549	25

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization JLR MANAGEMENT CORP.
Street Address 6633 NORTH LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 679-9141
Fax Number (847) 679-1820

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	54	9	\$ 100,000	\$ 100,000	5	\$ 9,259	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	54	9	5,000		5	463	2
3	21	OFFICE	AVG. HOURS WORKED	54	9	18,359	18,359	5	1,700	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	54	9	15,176		5	1,405	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 138,535	\$ 118,359		\$ 12,827	25

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance
Street Address 40 Skokie Blvd., Suite 105
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 599-1002
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Workers Compensation	Direct Allocation			\$	\$		\$ 318,575	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 318,575	25

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At South Shore # 0042085 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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							\$					\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6													6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	Interest Income											(2,258)	10
11	Alloc from Nucare											2,748	11
12	Alloc from Clinical Consult											153	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$					\$ 643	14
15	TOTALS (line 9+line14)						\$					\$ 643	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		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							\$					1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$					8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$					15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	481,476	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.)				\$	516,314	2
3. Under or (over) accrual (line 2 minus line 1).				\$	34,838	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	457,201	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.				\$	1,105	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.				\$	493,144	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	337,600	8	FOR BHF USE ONLY	
		2007	333,996	9		
		2008	337,347	10		
		2009	406,100	11		
		2010	507,745	12		
2011 Accrual= \$507,745 x.9=\$457,201				13	FROM R. E. TAX STATEMENT FOR 2010	13
Beginning Accrual Adjusted				14	PLUS APPEAL COST FROM LINE 5	14
Allocated from Nuicare \$8,569				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' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Renaissance At South Shore</u>	COUNTY	<u>Cook</u>
---------------	-----------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-101-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>39,523.69</u>	\$ <u>39,523.69</u>
2. <u>21-30-101-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>74,298.24</u>	\$ <u>74,298.24</u>
3. <u>21-30-101-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>202,272.26</u>	\$ <u>202,272.26</u>
4. <u>21-30-101-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>55,070.54</u>	\$ <u>55,070.54</u>
5. <u>21-30-101-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>136,580.26</u>	\$ <u>136,580.26</u>
6. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>81,875.48</u>	\$ <u>5,486.31</u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>589,620.47</u>	\$ <u>513,231.30</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Renaissance At South Shore</u>	COUNTY	<u>Cook</u>
---------------	-----------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

80,865

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Alloc from 7257 N. Lincoln & Clini	80,865	2004	\$ 10,721	1
2					2
3	TOTALS	80,865		\$ 10,721	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At South Shore

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1998		78,106		20	3,905	3,905	51,380
10	Various		1999		88,720		20	4,436	4,436	56,023
11	Various		2000		72,602		20	3,630	3,630	42,350
12	Various		2001		45,629		20	2,281	2,281	24,267
13	Various		2002		11,757		20	1,176	1,176	11,599
14	Various		2003		16,299		20	1,630	1,630	14,148
15	Various		2004		62,649		20	6,058	6,058	48,016
16	Various		2005		10,333		20	806	806	6,311
17	Various		2006		72,736		20	7,323	7,323	49,055
18	Various		2007		176,978		20	17,256	17,256	79,159
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

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		204,302	6,760		5,819	(941)	37,706	68
69	Financial Statement Depreciation			264,918			(264,918)		69
70	TOTAL (lines 4 thru 69)		\$ 840,110	\$ 271,678		\$ 54,321	\$ (217,357)	\$ 420,013	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance At South Shore

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 840,110	\$ 271,678		\$ 54,321	\$ (217,357)	\$ 420,013	1
2	Reface Hallway Doors; Cabinets & Desk Pt Office; Doors	2008	3,480		20	348	348	1,334	2
3	Heating/Cooling Plant	2008	2,835		20	283	283	1,039	3
4	Concrete Cutting & Installment Of Ramp	2008	8,000		20	800	800	2,800	4
5	Teledyne Laars Cooper Heat Exchanger	2008	2,869		20	287	287	980	5
6	Installed Furnished Tiles - Dinning Room	2008	3,482		20	348	348	1,161	6
7	Cabinetry For Office And Reception Area; Front Windows	2008	12,500		20	1,430	1,430	4,648	7
8	Remove Old Tub; Install New Tub	2008	3,000		20	300	300	1,000	8
9	New Duro Last Roofing System	2008	51,750		20	3,450	3,450	11,500	9
10	3Rd Flr Chair Rail, End Cap	2008	2,981		20	298	298	969	10
11	New Wallcovering	2008	16,698		20	1,670	1,670	5,427	11
12	Automatic Door Operating Equipment	2008	7,619		20	762	762	2,413	12
13	Pt Room And 4Th Floor Nursing Station Countertops; Reface Fro	2008	7,850		20	785	785	2,420	13
14	Pt Room Flooring; Build Office Space; Install Vinyl Plank Floorin	2008	8,790		20	879	879	2,710	14
15	Nathan Maple In Basement, 2Nd Floor, And Dining Room; Techn	2009	59,562		20	3,971	3,971	10,920	15
16	Cabinet Mail Box, Tv Stands, Servicing Units, Kitchen Counter At	2009	6,500		20	1,500	1,500	4,125	16
17	Heating And Air Conditioning System - Replacement	2009	15,320		20	1,277	1,277	3,511	17
18	Flooring Materials For 4Th Floor Corridor	2009	11,637		20	776	776	2,004	18
19	Additional Flooring Materials	2009	2,773		20	185	185	478	19
20	Light Fixtures, Light Switches, Circuit Panel	2009	5,525		20	553	553	1,381	20
21	Resident Room Painting	2009	12,350		20	1,235	1,235	3,190	21
22	2Nd & 4Th Floor- Wall Covering, Cove Base, Handrails, Paint	2009	92,038		20	9,204	9,204	23,009	22
23	Removing Wallpaper And Painting Resident Rooms	2009	18,475		20	1,848	1,848	4,311	23
24	Pleated Shades And Faux Wood Blinds	2009	4,670		20	467	467	1,090	24
25	Tadiran Ipx500 Telephone System	2009	24,875		20	2,488	2,488	6,011	25
26	2Nd And 4Th Flr- Lights, Signage, Wallcovering, Cove Base, Pain	2009	112,486		20	11,836	11,836	28,605	26
27	Vct Tile And Installation	2009	4,020		20	268	268	603	27
28	Usa Satellite Camera	2009	2,626		20	375	375	813	28
29	Handrails, Bumpers, Corner Guards, Cove Base, Etc	2009	15,860		20	3,172	3,172	6,873	29
30	Custom Office Cabinetry	2009	13,150		20	877	877	1,826	30
31	Copper Finned Boiler	2009	10,765		20	1,076	1,076	2,243	31
32	Wallcovering For Basement Corridor, Business Office, Mgrs Offic	2009	13,958		20	2,792	2,792	5,816	32
33	Ceramic Flooring For Shower Room	2009	3,910		20	261	261	543	33
34	TOTAL (lines 1 thru 33)		\$ 1,402,463	\$ 271,678		\$ 110,119	\$ (161,559)	\$ 565,765	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance At South Shore

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,402,463	\$ 271,678		\$ 110,119	\$ (161,559)	\$ 565,765	1
2	Chair Rail For 4Th Floor Resident Rooms	2009	6,803		20	1,361	1,361	2,835	2
3	Reface Front Lobby Doors & Window Ledges	2009	4,000		20	200	200	517	3
4	3Rd Floor Hallway Flooring	2010	22,858		20	3,540	3,540	7,080	4
5	Therapy Rm- Remove Flooring And Carpet, Prep And Level Floor	2010	9,752		20	1,950	1,950	3,901	5
6	Rewire Non Functionng Boiler	2010	2,789		20	279	279	535	6
7	Reface/Laminate 38 Patient Room Doors	2010	5,700		20	570	570	1,045	7
8	1St Flr Hallway Installation Natural 3" Vinyl Plank.	2010	11,780		20	2,356	2,356	4,123	8
9	Remove 850 Sq. Ft. Of 16" Decoria Tile. Prep And Level Floor Wi	2010	4,244		20	424	424	672	9
10	3 Rollershades, 4 Upholstered Cornice In Therapy Rm And Install	2010	7,245		20	725	725	1,449	10
11	2 Ctns Vinyl Cove Base 4" For Basement Area. Lobby; Furnish/In	2010	28,525		20	2,853	2,853	5,230	11
12	4 Light Fixtures - Entry; Various Signage For 3Rd Flr Corridor; I	2010	9,107		20	911	911	1,442	12
13	50% Deposit - Awnings Around Facility 4 Flrs 200Ft X 3Ft X 2Ft;	2010	8,150		20	815	815	1,155	13
14	Fabricate/Install 4 Cabinets, 36"W X 30"H X 12"D; 4 Base Cabin	2010	6,282		20	628	628	733	14
15	2 Light Fixtures Olympia; 2 Sconces Replacement For Lobby; 4 P	2010	3,517		20	352	352	557	15
16	Furnish/Install 36 Cordless Plus Premium Blinds In Hr; Med. Rec	2010	11,845		20	1,185	1,185	1,481	16
17	Remove Old Carpet, Install New Carpet, 4" Cove Base, Furnish C	2010	29,019		20	2,902	2,902	5,804	17
18	Remove 1036 Sq Ft. Decoria Tile, Prep And Level Flr, Furnish An	2010	6,797		20	680	680	1,076	18
19	Balance Due - Cherry Garden Mural - Alzheimer Unit	2010	2,600		20	130	130	184	19
20	3Rd Floor Bath - Remove Tile, Furnish & Install New Time, Prep	2010	3,172		20	159	159	278	20
21	Balance Due - Intall 16 Windows For 1St, 2Nd And 3Rd Floor Pat	2010	4,973		20	249	249	394	21
22	Paint Molding	2010	2,999		20	150	150	237	22
23	Prime Vestibule Reception & 3Rd Floor Hall	2010	4,925		20	246	246	431	23
24	300 Ft 5 1/2 Ft Hand Rail Honduras Mahogany, 58 Pcs End Cap, 2	2011	7,591		20	380	380	380	24
25	Electrical Work For Crd Access Expansion	2011	5,700		20	570	570	570	25
26	Painting Of 32 Resident Rooms Walls, Bathrooms, Therapy Rm, S	2011	18,085		20	904	904	776	26
27	Removal Of Nurses Station - 50% Deposit	2011	7,710		20	643	643	643	27
28	Fabricate And Install Cabinets In 4 Shower Rooms 50% Deposit	2011	5,852		20	439	439	439	28
29	50% Balance, Awnings Around Facility, 1 Patio Awning, 1 Back D	2011	8,150		20	611	611	611	29
30	Furnish And Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	5,386		20	404	404	404	30
31	Labor To Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	4,486		20	336	336	336	31
32	Replace Corridor Lay In Lighting W/ Corelite T5 On 2Nd, 3Rd Ar	2011	14,575		20	972	972	972	32
33	Dining Room Expansion-Demolition,Carpentry,Insulation,Efis,Ce	2011	48,300		20	3,220	3,220	3,220	33
34	TOTAL (lines 1 thru 33)		\$ 1,725,380	\$ 271,678		\$ 141,261	\$ (130,417)	\$ 615,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance At South Shore

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 12C, Carried Forward		\$ 1,725,380	\$ 271,678		\$ 141,261	\$ (130,417)	\$ 615,272	1
2	Furnish And Install 6 Oak Doors, 2 Drawers And Drwr Fronts In	2011	6,884		20	229	229	229	2
3	Balance Due-Remodeling Of Dining Rooms-Demolition,Carpentry	2011	11,491		20	670	670	670	3
4	Fabricate And Install One New Flex Sign Face To Replace Existing	2011	13,625		20	530	530	530	4
5	Replace 20 Lights, 1St Flr Corridor, 4Th Flr, 29 Wall Sconce Ligh	2011	10,265		20	513	513	513	5
6	Construction Of 4Th Flr Conference Room, Installation Of Cabin	2011	8,294		20	622	622	622	6
7	3Rd Flr Bathroom Remodel-Remove Wall Tile,Replace Drywall,C	2011	6,050		20	303	303		7
8	Shower Rm-Tile,Waterproof Membrane,Ceramic Adhesive,Lactic	2011	17,407		20				8
9	Service To Vac Out Set Of Triple Drains And A Catch Basin And	2011	2,725		20	136	136	136	9
10	Uninstall Various Electrical Wiring Piping Junction Boxes And To F	2011	3,125		20	156	156	156	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,805,246	\$ 271,678		\$ 144,420	\$ (127,258)	\$ 618,129	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,805,246	\$ 271,678		\$ 144,420	\$ (127,258)	\$ 618,129	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,805,246	\$ 271,678		\$ 144,420	\$ (127,258)	\$ 618,129	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance At South Shore

0042085

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from NuCare 7257 N. Lincoln Ave	2004	91,413	2,344	35	2,612	268	21,221	3
4	Allocated from Clinical Consulting Services	2004	5,078	130	35	145	15	1,179	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare	2003	826	36	20	41	5	336	9
10	Allocated from NuCare	2004	65,919	729	20	840	111	6,474	10
11	Allocated from NuCare	2005	994	43	20	50	7	341	11
12	Allocated from NuCare	2006	1,348	59	20	67	8	362	12
13	Allocated from NuCare	2008	1,421	62	20	71	9	231	13
14	Allocated from NuCare	2009	22,883	3,130	20	1,144	(1,986)	2,986	14
15	Allocated from NuCare	2010	3,516	153	20	176	23	265	15
16	Allocated from NuCare	2011	190	8	20	9	1	9	16
17									17
18	Allocated from NuCare 7257 N. Lincoln Ave	2004	1,817		20	91	91	681	18
19	Allocated from NuCare 7257 N. Lincoln Ave	2005	8,333	63	20	538	475	3,394	19
20	Allocated from Clinical Consulting Services	2004	101		20	5	5	38	20
21	Allocated from Clinical Consulting Services	2005	463	3	20	30	27	189	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 204,302	\$ 6,760		\$ 5,819	\$ (941)	\$ 37,706	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 857,923	\$ 2,260	\$ 104,363	\$ 102,103	10	\$ 564,372	71
72	Current Year Purchases	52,398	265	6,043	5,778	10	6,043	72
73	Fully Depreciated Assets	275,090		142	142	10	275,090	73
74								74
75	TOTALS	\$ 1,185,411	\$ 2,525	\$ 110,549	\$ 108,024		\$ 845,505	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from NuCare	2011	\$ 625	\$ 27	\$ 125	\$ 98	5	\$ 177	76
77										77
78										78
79										79
80	TOTALS			\$ 625	\$ 27	\$ 125	\$ 98		\$ 177	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,002,003	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 274,230	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 255,094	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,136)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,463,811	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: South Shore Partnership
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:	1998	248		\$ 1,904,560			3
4	Additions							4
5	Parking Rent				360			5
6	Allocated from NuCare				451			6
7	TOTAL		248		\$ 1,905,371			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:
- *

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: \$ 30,620
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

		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 - 03	hrs	\$		\$ 437,737	\$		\$ 437,737	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			216,817			216,817	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			423,811			423,811	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				578,587		578,587	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			6,062		12,773	110,486		129,321	13
14	TOTAL			\$ 6,062		\$ 1,091,138	\$ 689,073		\$ 1,786,273	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,763	\$	1
2	Cash-Patient Deposits	20,438		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,935,226		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	193,299		6
7	Other Prepaid Expenses	217,231		7
8	Accounts Receivable (owners or related parties)	15,785,958		8
9	Other(specify): See Attached Schedule	1,225,282		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,385,197	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,293,727		15
16	Equipment, at Historical Cost	1,113,830		16
17	Accumulated Depreciation (book methods)	(2,003,118)		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): See Attached Schedule	27,930		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,432,369	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,817,566	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,215,453	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,595		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	527,799		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,317		31
32	Accrued Real Estate Taxes(Sch.IX-B)	457,201		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	15,428,384		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 19,679,749	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,679,749	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,137,817	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 23,817,566	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,991,992	1
2	Restatements (describe):		2
3	Medicare Bad Debt	(164,230)	3
4	Depreciation Adjustment	(1,018)	4
5	Computer Expense	(3,500)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,823,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	314,573	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)	\$ 314,573	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)	\$ 4,137,817	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,954,189	1
2	Discounts and Allowances for all Levels	(287,074)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,667,115	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,786,357	6
7	Oxygen	11,092	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,797,449	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,258,068	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	115,179	19
20	Radiology and X-Ray	18,239	20
21	Other Medical Services	165,946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,557,432	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,258	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,258	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,582	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,582	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,025,836	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,121,413	31
32	Health Care	6,235,296	32
33	General Administration	4,951,378	33
	B. Capital Expense		
34	Ownership	2,680,390	34
	C. Ancillary Expense		
35	Special Cost Centers	2,275,545	35
36	Provider Participation Fee	447,241	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,711,263	40
41	Income before Income Taxes (line 30 minus line 40)**	314,573	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 314,573	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,544	1,756	\$ 70,379	\$ 40.08	1
2	Assistant Director of Nursing	2,387	2,558	93,780	36.66	2
3	Registered Nurses	38,309	40,936	1,273,281	31.10	3
4	Licensed Practical Nurses	54,221	59,846	1,431,315	23.92	4
5	CNAs & Orderlies	151,056	165,435	1,833,023	11.08	5
6	CNA Trainees					6
7	Licensed Therapist	160	160	6,062	37.89	7
8	Rehab/Therapy Aides	14,079	15,616	178,797	11.45	8
9	Activity Director	3,656	4,040	69,777	17.27	9
10	Activity Assistants	12,390	13,776	147,987	10.74	10
11	Social Service Workers	8,112	9,295	174,930	18.82	11
12	Dietician	2,726	3,018	74,023	24.53	12
13	Food Service Supervisor	320	354	8,688	24.54	13
14	Head Cook	5,833	6,614	95,588	14.45	14
15	Cook Helpers/Assistants	22,835	25,105	252,144	10.04	15
16	Dishwashers					16
17	Maintenance Workers	5,439	5,670	111,904	19.74	17
18	Housekeepers	23,033	24,934	251,084	10.07	18
19	Laundry	12,234	13,643	150,195	11.01	19
20	Administrator	1,949	2,086	153,969	73.81	20
21	Assistant Administrator	1,981	2,086	65,595	31.45	21
22	Other Administrative	160	160	14,522	90.76	22
23	Office Manager	226	283	5,613	19.83	23
24	Clerical	11,659	12,556	284,762	22.68	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	1,914	2,231	65,296	29.27	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	10,569	11,786	320,835	27.22	33
34	TOTAL (lines 1 - 33)	386,792	423,944	\$ 7,133,549 *	\$ 16.83	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	351	\$ 16,480	01-03	35
36	Medical Director	Monthly	82,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	317	6,237	10-03	38
39	Pharmacist Consultant	Monthly	15,047	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	29	1,711	12-03	45
46	Other(specify)				46
47	Psychological Consultant	7	339	12-03	47
48	Therapy	18	885	10a-03	48
49	TOTAL (lines 35 - 48)	721	\$ 122,999		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	40	1,440	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	40	\$ 1,440		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Renaissance At South Shore		STATE OF ILLINOIS		Page 21		
				# 0042085		Report Period Beginning: 01/01/11		
						Ending: 12/31/11		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Connie Ortega	Administrator	0.00	\$ 99,502	Workers' Compensation Insurance	\$ 318,575	IDPH License Fee	\$ 808	
Kevin J McInerney	Assistant Admin	0.00	65,595	Unemployment Compensation Insurance	174,515	Advertising: Employee Recruitment	39,497	
Frederick Ramos	Administrative	0.00	54,467	FICA Taxes	531,171	Health Care Worker Background Check		
Marilyn Flaherty	VP Medicare Reimbursement	0.00	14,522	Employee Health Insurance	330,301	(Indicate # of checks performed 318)	3,348	
				Employee Meals	25,550	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	23,705	
				Union Pension	62,650	Dues and Subscriptions	1,089	
				Dental Insurance	8,418	Licenses and Fees	6,112	
				City Payroll Tax	9,224	Allocated from NuCare	1,198	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	26,569	See Supplemental Schedule	35	
(List each licensed administrator separately.)			\$ 234,086	401K Expense	1,365	Less: Public Relations Expense	()	
B. Administrative - Other				Vision Insurance	128	Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
JLR Management-Management Fees			\$ 65,000					
Nucare Service Corporation-Administrative Fee			970,969					
CCS - Administrative Fee			64,974					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,100,943	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,488,466	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Frost, Ruttenberg & Rothblatt	Accounting		\$ 26,943					
Risk Management Services	Risk Management		8,000					
Emdeon Business Solution	Computer Services		565					
Giftwrap	Computer Services		2,408				In-State Travel	
HDSI	Computer Services		4,291					
MDI Achieve	Computer Services		25,046					
Personnel Planners	Unemployment Consultants		6,038					
Documentation Solutions	Reimb Consulting		3,606				Seminar Expense	11,959
See Attached	Legal Fees		109,576				Allocated from NuCare	306
							Allocated from Clinical Consulting	227
TOTAL (agree to Schedule V, line 19, column 3)							Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 186,473	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 12,492

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

LILCLTC \$23,705
- (3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$5,212

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.

\$447,241

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$25,550

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?

1005 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?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No

g. Does the facility transport residents to and from day training?

N/A

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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT