

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0049098</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Renaissance Park South</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</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>10935 S. Halsted Street</u> <u>Chicago</u> <u>60028</u>																									
NumberCityZip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 928-2000</u> Fax # <u>(773) 928-9670</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>07/01/07</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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	☒ "Sub-S" Corp.																								
	☐ 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 Park South

0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	300	Skilled (SNF)	300	109,800	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	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			13,075	13,075	8
9	SNF/PED					9
10	ICF	66,309	3,464	4,411	74,184	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,309	3,464	17,486	87,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.47%

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

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

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

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

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 05/01/1976

J. Was the facility purchased or leased after January 1, 1978? YES NO X

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 300 and days of care provided 11,935

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	425,337	125,081	13,736	564,154		564,154		564,154			1
2	Food Purchase		415,196		415,196	(34,496)	380,701	(164)	380,536			2
3	Housekeeping	1,759	31,605	319,478	352,842		352,842		352,842			3
4	Laundry	1,378	49,767	212,985	264,130		264,130		264,130			4
5	Heat and Other Utilities			226,590	226,590		226,590	(15,294)	211,296			5
6	Maintenance	118,384	98,761	209,105	426,250		426,250	18,772	445,022			6
7	Other (specify):*											7
8	TOTAL General Services	546,858	720,410	981,894	2,249,162	(34,496)	2,214,667	3,314	2,217,980			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800		28,800			9
10	Nursing and Medical Records	4,954,382	678,527	91,396	5,724,305		5,724,305	(23,339)	5,700,966			10
10a	Therapy	80,999			80,999		80,999		80,999			10a
11	Activities	155,984	28,931		184,915		184,915	666	185,581			11
12	Social Services	200,606		5,340	205,946		205,946		205,946			12
13	CNA Training											13
14	Program Transportation			723	723		723		723			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,391,971	707,458	126,259	6,225,688		6,225,688	(22,673)	6,203,015			16
	C. General Administration											
17	Administrative	170,491		753,905	924,396		924,396	(715,502)	208,894			17
18	Directors Fees											18
19	Professional Services			195,366	195,366	(149)	195,217	(72,416)	122,801			19
20	Dues, Fees, Subscriptions & Promotions			148,024	148,024		148,024	(88,676)	59,348			20
21	Clerical & General Office Expenses	289,876	58,947	575,274	924,097		924,097	(276,296)	647,801			21
22	Employee Benefits & Payroll Taxes			1,401,105	1,401,105	34,496	1,435,601		1,435,601			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,414	21,414		21,414	(2,770)	18,644			24
25	Other Admin. Staff Transportation			1,912	1,912		1,912	2,095	4,007			25
26	Insurance-Prop.Liab.Malpractice			1,044,531	1,044,531		1,044,531	300	1,044,831			26
27	Other (specify):*							55,198	55,198			27
28	TOTAL General Administration	460,367	58,947	4,141,531	4,660,845	34,347	4,695,192	(1,098,066)	3,597,126			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,399,196	1,486,815	5,249,684	13,135,695	(149)	13,135,546	(1,117,425)	12,018,121			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			281,855	281,855		281,855	470,397	752,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,623	56,623		56,623	821,588	878,211			32
33	Real Estate Taxes					149	149	605,729	605,877			33
34	Rent-Facility & Grounds			1,866,259	1,866,259		1,866,259	(1,859,416)	6,843			34
35	Rent-Equipment & Vehicles			24,930	24,930		24,930	7,164	32,094			35
36	Other (specify):*							9,340	9,340			36
37	TOTAL Ownership			2,229,667	2,229,667	149	2,229,816	54,801	2,284,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		660,214	1,381,130	2,041,344		2,041,344	(13,091)	2,028,253			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			507,036	507,036		507,036		507,036			42
43	Other (specify):*	143,724		156,608	300,332		300,332	(300,332)	0			43
44	TOTAL Special Cost Centers	143,724	660,214	2,044,774	2,848,712		2,848,712	(313,423)	2,535,289			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,542,920	2,147,029	9,524,125	18,214,074	(0)	18,214,074	(1,376,047)	16,838,027			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	(18,621)	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	237,925	30		9
10	Interest and Other Investment Income	(2,116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(164)	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	(3,298)	24		19
20	Contributions	(25,725)	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	(461,220)	21		24
25	Fund Raising, Advertising and Promotional	(51,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(560,439)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (885,213)		\$	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)	(490,833)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (490,833)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,376,047)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Renaissance Park South

	ID#	0049098
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Copy Income	\$ (722)	21	1
2	Jury Duty Income	(222)	10	2
3	Patient Needs	(13,742)	10	3
4	Patient Clothing	(3,950)	10	4
5	Veterans Expenses	(32,419)	10	5
6	Bank Charges	(20,839)	21	6
7	IL Replacement Tax	(2,858)	21	7
8	Collection Expense	(13,813)	21	8
9	Annual Report	(250)	20	9
10	Non-Allowable Legal Fees	(76,988)	19	10
11	Additional R&M	10,131	06	11
12	Non-Allowable Expense	(156,608)	43	12
13	Bldg Co: Accounting Fees	(4,615)	19	13
14	Bldg Co: Professional Fees - Other	(6,000)	19	14
15	Bldg Co: Bank Charges	(4)	21	15
16	Bldg Co: Amortization of Loan Costs	(9,490)	36	16
17	Bldg Co: Amortization - Interest Cap Agrmt	(39,333)	36	17
18	Guest Services Salary	(58,947)	43	18
19	Community Related Salary	(56,234)	43	19
20	Non-Reimbursable Salaries	(28,543)	43	20
21	COPE Dues	(11,852)	20	21
22	Non-Reimbursable Wages	(29,141)	21	22
23	Non-Allowable Wages	(4,000)	17	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(560,439)		49

ID#0049098

Report Period Beginning:01/01/12

Ending:12/31/12

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

Summary A

12/31/12

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
30	Depreciation	237,925	220,679	11,624	169								470,397	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,116)	821,353	2,227	124								821,588	32
33	Real Estate Taxes		596,188	9,541									605,729	33
34	Rent-Facility & Grounds		(1,860,000)	584									(1,859,416)	34
35	Rent-Equipment & Vehicles			6,696	468								7,164	35
36	Other (specify):*	(48,823)	58,163										9,340	36
37	TOTAL Ownership	186,986	(163,617)	30,671	761								54,801	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(13,091)						(13,091)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(300,332)											(300,332)	43
44	TOTAL Special Cost Centers	(300,332)					(13,091)						(313,423)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(885,213)	(152,998)	(318,595)	(6,149)		(13,091)						(1,376,047)	45

VII. RELATED PARTIES

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

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

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,860,000	Halsted Associates Limited Partnership	100.00%	\$	\$ (1,860,000)	1
2	V	32	Interest	6,069	Halsted Associates Limited Partnership	100.00%		(6,069)	2
3	V	36	MIP Expense		Halsted Associates Limited Partnership	100.00%	9,340	9,340	3
4	V	19	Accounting Fees		Halsted Associates Limited Partnership	100.00%	4,615	4,615	4
5	V	19	Professional Fees - Other		Halsted Associates Limited Partnership	100.00%	6,000	6,000	5
6	V	21	Bank Charges		Halsted Associates Limited Partnership	100.00%	4	4	6
7	V	32	Mortgage Interest		Halsted Associates Limited Partnership	100.00%	827,422	827,422	7
8	V	33	Real Estate Taxes		Halsted Associates Limited Partnership	100.00%	596,188	596,188	8
9	V	30	Depreciation		Halsted Associates Limited Partnership	100.00%	220,679	220,679	9
10	V	36	Amortization of Loan Costs		Halsted Associates Limited Partnership	100.00%	9,490	9,490	10
11	V	36	Amort. Of Interest Cap Agrmt		Halsted Associates Limited Partnership	100.00%	39,333	39,333	11
12	V								12
13	V								13
14	Total			\$ 1,866,069			\$ 1,713,071	\$ * (152,998)	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%	\$ 3,327	\$	3,327 15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,559		8,559 16
17	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	10,492		10,492 17
18	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	42,402		42,402 18
19	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	4,572		4,572 19
20	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	592		592 20
21	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	222,178		222,178 21
22	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	155		155 22
23	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,609		1,609 23
24	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	171		171 24
25	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	53,218		53,218 25
26	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	11,624		11,624 26
27	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,227		2,227 27
28	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	9,541		9,541 28
29	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	584		584 29
30	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	6,696		6,696 30
31	V								31
32	V	17	BOOKKEEPING FEES	696,542	NUCARE SERVICES CORP.	100.00%			(696,542) 32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 696,542			\$ 377,947	\$ *	(318,595) 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	REPAIRS / MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 82	\$ 82	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	16,502	16,502	16
17	V	11	ACTIVITY CONSULTANT		CLINICAL CONSULTING SERVICES, LLC	100.00%	666	666	17
18	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			18
19	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	114	114	19
20	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	28,634	28,634	20
21	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,486	1,486	21
22	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	373	373	22
23	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	486	486	23
24	V	26	AUTO INSURANCE		CLINICAL CONSULTING SERVICES, LLC	100.00%	129	129	24
25	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,988	1,988	25
26	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	(8)	(8)	26
27	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	169	169	27
28	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	124	124	28
29	V	34	RENT		CLINICAL CONSULTING SERVICES, LLC	100.00%			29
30	V	35	AUTO LEASE		CLINICAL CONSULTING SERVICES, LLC	100.00%	468	468	30
31	V								31
32	V	17	ADMINISTRATIVE FEES	57,362	CLINICAL CONSULTING SERVICES, LLC	100.00%		(57,362)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 57,362			\$ 51,213	\$ * (6,149)	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	Workers Compensation	\$ 241,649	DIAMOND INSURANCE		\$ 241,649	\$	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			\$ 241,649			\$ 241,649	\$ *	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	39	DME and Medical Supplies	71,262	Integra Healthcare Equipment	100.00%	58,171	\$ (13,091)	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			\$ 71,262			\$ 58,171	\$ * (13,091)	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 (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

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	4.950%	CALIFORNIA GARDENS CORP.	CHICAGO	HALSTED ASSOCIATES LIMITED	CHICAGO	BUILDING CO.	1
2	CHAIM RAJCHENBACH	5.220%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	CLINICAL CONSULTING SERVICES	LINCOLNWOOD	CLINICAL CONSULTING	2
3	DAVID HARTMAN	8.240%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	FARHAT SHARIF	2.750%	CLARIDGE IMPERIAL, LTD.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	4
5	GERRY JENICH	8.240%	JACKSON CORP.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	5
6	RAJCHENBACH FAMILY TRUST	23.080%	MONROE CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	6
7	ROBERT HARTMAN FAMILY TRUST	21.980%	RENAISSANCE EAST	MESA, ARIZONA	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	7
8	ROBERT & DEBERRA FAMILY FOUNDATION	3.020%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	LOUIS DRAKE ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	8
9	ROBERT HARTMAN DYNASTY TRUST	3.300%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP INS.	9
10	ROBERT HARTMAN - SERIES H	19.230%	RENAISSANCE WEST	MESA, ARIZONA	JLR FINANCIAL SERVICES	LINCOLNWOOD	MANAGEMENT CO.	10
11			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	INTEGRA HEALTHCARE EQUIPMENT	ELMHURST	DME & MEDICAL SUPPLIES	11
12			ARIA POST ACUTE CARE	HILLSDALE	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	12
13			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO				14
15			CLAREMONT HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC,				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	1,228,556	15	\$ 37,226	\$	109,800	\$ 3,327	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,228,556	15	95,768		109,800	8,559	2
3	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,228,556	15	117,394	117,394	109,800	10,492	3
4	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,228,556	15	474,443	462,325	109,800	42,402	4
5	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,228,556	15	51,153		109,800	4,572	5
6	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,228,556	15	6,629		109,800	592	6
7	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,228,556	15	2,485,957	1,190,733	109,800	222,178	7
8	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,228,556	15	1,734		109,800	155	8
9	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,228,556	15	18,004		109,800	1,609	9
10	26	INSURANCE	AVAIL. CENSUS DAYS	1,228,556	15	1,913		109,800	171	10
11	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,228,556	15	595,462		109,800	53,218	11
12	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,228,556	15	130,061		109,800	11,624	12
13	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,228,556	15	24,917		109,800	2,227	13
14	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,228,556	15	106,750		109,800	9,541	14
15	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,228,556	15	6,532		109,800	584	15
16	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,228,556	15	74,917		109,800	6,696	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,228,859	\$ 1,770,453		\$ 377,947	25

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	REPAIRS / MINOR EQUIPMEN	BED DAYS AVAILABLE	1,228,556	15	\$ 920	\$	109,800	\$ 82	1
2	10	CLINICAL SALARIES	BED DAYS AVAILABLE	1,228,556	15	184,643	184,643	109,800	16,502	2
3	11	ACTIVITY CONSULTANT	BED DAYS AVAILABLE	1,228,556	15	7,452	7,452	109,800	666	3
4	19	PROFESSIONAL FEES	BED DAYS AVAILABLE	1,228,556	15			109,800		4
5	20	DUES, LICENSE & INSPECTION	BED DAYS AVAILABLE	1,228,556	15	1,272		109,800	114	5
6	21	OFFICE WAGES	BED DAYS AVAILABLE	1,228,556	15	320,385	320,385	109,800	28,634	6
7	21	OFFICE EXPENSE	BED DAYS AVAILABLE	1,228,556	15	16,624		109,800	1,486	7
8	24	CONTINUING EDUCATION / ST	BED DAYS AVAILABLE	1,228,556	15	4,175		109,800	373	8
9	25	AUTO EXPENSE	BED DAYS AVAILABLE	1,228,556	15	5,436		109,800	486	9
10	26	AUTO INSURANCE	BED DAYS AVAILABLE	1,228,556	15	1,447		109,800	129	10
11	27	PAYROLL TAXES	BED DAYS AVAILABLE	1,228,556	15	22,241		109,800	1,988	11
12	27	OTHER EMPLOYEE BENEFITS	BED DAYS AVAILABLE	1,228,556	15	(91)		109,800	(8)	12
13	30	DEPRECIATION	BED DAYS AVAILABLE	1,228,556	15	1,892		109,800	169	13
14	32	INTEREST	BED DAYS AVAILABLE	1,228,556	15	1,384		109,800	124	14
15	34	RENT	BED DAYS AVAILABLE	1,228,556	15			109,800		15
16	35	AUTO LEASE	BED DAYS AVAILABLE	1,228,556	15	5,242		109,800	468	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 573,023	\$ 512,480		\$ 51,213	25

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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) 559-1002
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 241,649	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					\$	\$		\$ 241,649	25

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME and Medical Supplies	Direct Allocation						58,171	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					\$	\$		\$ 58,171	25

Facility Name & ID Number Renaissance Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Park South # 0049098 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Private Bank		X	Mortgage			\$	16,820,000			\$ 827,422	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Loan										56,623	6	
7												7	
8	See Supplemental Schedule										2,351	8	
9	TOTAL Facility Related						\$	16,820,000			\$ 886,397	9	
	B. Non-Facility Related*												
10	Interest Income		X								(2,116)	10	
11	Interest Income - Bldg Co.		X								(6,069)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ (8,185)	14	
15	TOTALS (line 9+line14)						\$	16,820,000			\$ 878,212	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,340 Line # 36

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

SEE ACCOUNTANTS' 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 - 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	Allocated from Nucare		X				\$	\$			\$ 2,227	8	
9	Allocated from CCS		X								124	9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										2,351	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.)

** 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 (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	453,936	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.)		\$	521,796	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	67,860	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	537,868	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.		\$	149	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.		\$	605,877	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	324,203	8	
		2008	327,675	9	
		2009	547,966	10	
		2010	432,320	11	
		2011	512,255	12	
2012 Accrual = \$432,320 x 1.05 = \$453,936					
Allocated from NuCare \$9,541					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Renaissance Park South</u>	COUNTY	<u>Cook</u>
---------------	-------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0049098

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 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>50,334.78</u>	\$ <u>50,334.78</u>
2. <u>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>48,832.37</u>	\$ <u>48,832.37</u>
3. <u>25-16-332-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>167,477.91</u>	\$ <u>167,477.91</u>
4. <u>25-16-332-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>245,610.41</u>	\$ <u>245,610.41</u>
5. <u>See Attached</u>	<u>Allocated from NuCare</u>	\$ <u>84,353.24</u>	\$ <u>6,785.03</u>
6. <u>See Attached</u>	<u>Allocated from CCS</u>	\$ <u>84,353.24</u>	\$ <u>376.95</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>680,961.95</u>	\$ <u>519,417.45</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance Park South COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049098

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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? YES NO

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

60,068

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 855,000	1
2	Allocated From 7257 N. Lincoln/Clinical Constl.			13,585	2
3	TOTALS			\$ 868,585	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance Park South

0049098

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	300			1976	\$ 7,334,294	\$	39	\$ 366,715	\$ 366,715	\$ 6,937,025	4	
5				1994	554,636		39	27,732	27,732	330,054	5	
6				1994	3,020		39	151	151	1,788	6	
7				1994	106,949		39	5,347	5,347	64,782	7	
8											8	
	Improvement Type**											
9	Various			1978	750		20			750	9	
10	Various			1979	12,807		20			12,749	10	
11	Various			1980	35,915		20			35,915	11	
12	Various			1981	13,910		20			13,910	12	
13	Various			1982	8,814		20			8,814	13	
14	Various			1983	12,936		20			12,936	14	
15	Various			1984	20,560		20			20,560	15	
16	Various			1985	18,883		20			18,874	16	
17	Various			1986	2,456		20			2,456	17	
18	Various			1987	4,000		20	127	127	3,226	18	
19	Various			1988	82,596		20	2,622	2,622	63,496	19	
20	Various			1989	1,225		20	39	39	911	20	
21	Various			1990	91,597		20	1,128	1,128	71,326	21	
22	Various			1993	53,620		20	1,730	1,730	52,474	22	
23	Various			1995	137,949		20	6,733	6,733	120,243	23	
24	Various			1996	519,100		20	26,418	26,418	451,310	24	
25	Various			1997	76,548		20	3,747	3,747	60,018	25	
26	Various			1998	77,488		20	3,874	3,874	56,234	26	
27	Various			1999	278,572		20	13,863	13,863	192,488	27	
28	Various			2000	48,393		20	2,246	2,246	28,504	28	
29	Various			2001	97,460		20	4,812	4,812	55,650	29	
30	Various			2002	25,280		20	927	927	25,280	30	
31	Various			2003	461,684		20	38,793	38,793	371,219	31	
32	Various			2004	62,146		20	3,240	3,240	57,651	32	
33	Various			2005	94,134		20	4,343	4,343	94,445	33	
34	Various			2006	114,124		20	4,229	4,229	98,974	34	
35	Various			2007	377,501		20	27,803	27,803	160,699	35	
36	Various			2008	823,017		20	42,069		198,671	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

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)		50,886	220,678		2,545	(218,133)	47,948	67
68	Related Party Allocations (Pages 12H & 12I)		196,869	6,699		7,382	683	55,159	68
69	Financial Statement Depreciation			281,855			(281,855)		69
70	TOTAL (lines 4 thru 69)		\$ 11,800,120	\$ 509,232		\$ 598,614	\$ 47,313	\$ 9,726,539	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 Park South

0049098

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 11,800,120	\$ 509,232		\$ 598,614	\$ 89,382	\$ 9,726,539	1
2	8 Wall A/C	2009	8,147		20	1,164	1,164	4,171	2
3	Tadiran Ipx500 Telephone System	2009	59,950		20	5,995	5,995	19,983	3
4	14 Roof Exhaust Fans	2009	9,672		20	484	484	1,934	4
5	Volt Line For Heater; Heater; Lighting In Conference Room	2009	2,940		20	147	147	576	5
6	Kitchen Tiles Repair	2009	7,750		20	517	517	1,981	6
7	Econocare - Doors, Ceiling, Tiles, Light Fixtures	2009	42,621		20	2,131	2,131	7,991	7
8	Motorized Door Opener	2009	3,309		20	165	165	634	8
9	Installation Of 18 Outlets	2009	8,733		20	437	437	1,601	9
10	Door Monitor Panels; Indoor Doorguard; Dome Cameras; Weath	2009	10,692		20	1,527	1,527	5,728	10
11	Replaced Valves In Refrigerator	2009	3,021		20	432	432	1,547	11
12	Rewiring Cables At South Stairwell	2009	3,150		20	450	450	1,613	12
13	20 Amps Circuit Breakers	2009	3,270		20	163	163	572	13
14	Common Signage	2009	5,967		20	597	597	2,387	14
15	Compressors For Chiller On Roof	2009	10,918		20	546	546	1,956	15
16	Electrical Work	2009	3,230		20	162	162	498	16
17	Carpeting, Walls, Tiles, Light Fixtures	2009	68,720		20	4,584	4,584	14,321	17
18	Boiler Repair	2009	12,208		20	814	814	3,155	18
19	Actuator, Valves	2009	2,818		20	188	188	634	19
20	Reverse Prior Year Remodeling Work	2010	(6,112)		20	(306)	(306)	(917)	20
21	Bathroom Fixtures & Appliances	2010	7,087		20	354	354	797	21
22	Kitchen Remodeling-Walls, Plumbing, Electrical Work, Cabinetry	2010	16,778		20	839	839	2,027	22
23	Shower Room Remodeling-Walls, Electrical Work, Fixtures	2010	41,069		20	2,053	2,053	4,963	23
24	Wanderguard System	2010	3,745		20	187	187	421	24
25	Light Fixtures And Wallpaper	2010	5,099		20	255	255	744	25
26	Cables, Dvr, Monitors	2010	4,396		20	440	440	1,319	26
27	Painting	2010	35,705		20	1,785	1,785	5,356	27
28	Crown Molding, Partitions	2010	12,050		20	603	603	1,808	28
29	Exhaust Fans	2010	4,189		20	209	209	628	29
30	Upgrade Fire System	2010	3,524		20	503	503	1,384	30
31	Rooftop Air Conditioner	2010	65,684		20	5,474	5,474	13,684	31
32	Landscaping Improvements	2010	6,500		20	433	433	1,083	32
33	Electrical For Chiller	2010	4,820		20	241	241	582	33
34	TOTAL (lines 1 thru 33)		\$ 12,271,770	\$ 509,232		\$ 632,188	\$ 122,956	\$ 9,831,701	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 Park South

0049098

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,271,770	\$ 509,232		\$ 632,188	\$ 122,956	\$ 9,831,701	1
2	Boiler Repairs	2010	6,509		20	325	325	949	2
3	Painting Of 54 Rooms On 3Rd Flr, Patch Holes And Cracks In Wa	2011	11,000		20	550	550	1,008	3
4	Fabricate, Install And Secur To Wall 30 Linear Ft. Upper Storage	2011	5,000		20	1,000	1,000	1,917	4
5	10 Cubicle Curtain Color Dune, 10 Cubicle Color Harvest	2011	2,830		20	566	566	943	5
6	Labor And Materials To Replace R&R Door Board Of South Elev	2011	4,195		20	210	210	350	6
7	Painting 56 Rooms, Door Frames, Install Base Moldings On 2Nd F	2011	17,500		20	875	875	1,385	7
8	Bathroom Remodel - Lighting, Ceiling, Shower, Tile, Sinks, Toilet	2011	63,980		20	3,199	3,199	5,065	8
9	Bathroom Remodel - Drywall, Paint, Tile, Mirror, Sink, Toilet	2011	2,800		20	140	140	198	9
10	Widen Entrance To 3 North And 2 North Tub Rooms, Furnish/Ins	2011	2,996		20	150	150	212	10
11	Bathroom Remodel - Drywall, Paint, Tile, Mirror, Sink, Toilet	2011	2,800		20	140	140	187	11
12	Install Security System-1 Camera Outside North Wall, 2 Cameras	2011	8,580		20	1,226	1,226	1,532	12
13	Fan Motors And Exhausts Vents On Roof	2011	5,558		20	278	278	394	13
14	Hot Water Repair	2011	2,760		20	138	138	276	14
15	Replace Hot Water Boiler	2012	8,495		20	389	389	389	15
16	Sprinkler System Modifications	2012	16,748		20	598	598	598	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)		\$ 12,433,521	\$ 509,232		\$ 641,972	\$ 132,740	\$ 9,847,105	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	Totals from Page 12C, Carried Forward		\$12,433,521	\$509,232		\$641,972	\$132,740	\$9,847,105	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)		\$12,433,521	\$509,232		\$641,972	\$132,740	\$9,847,105	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	Totals from Page 12D, Carried Forward		\$ 12,433,521	\$ 509,232		\$ 641,972	\$ 132,740	\$ 9,847,105	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)		\$ 12,433,521	\$ 509,232		\$ 641,972	\$ 132,740	\$ 9,847,105	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 Park South

0049098

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Landscaping	1994	25,996		20	1,300	1,300	27,296	9
10	Sprinkler System	1994	8,900		20	445	445	9,345	10
11	Sign- Awning	1994	9,474		20	474	474	9,948	11
12	Repair Hot Water System Causing Flood	2008	3,256		20	163	163	693	12
13	Installation of 240 Volt Line for Hall Heater; Removed & Replace	2008	3,260		20	163	163	666	13
14									14
15	Depreciation			220,678			(220,678)		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 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	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)		\$ 50,886	\$ 220,678		\$ 2,545	\$ (218,133)	\$ 47,948	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 Park South

0049098

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 7257 N. Lincoln Ave, LLC	2004	115,828	2,970	35	3,309	339	30,198	3
4	Allocated from Clinical Consulting Services	2004	6,435	165	35	184	19	1,678	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare Services Corp.	2003	1,047	60	20	52	(8)	477	9
10	Allocated from NuCare Services Corp.	2004	21,253	1,214	20	1,064	(150)	9,267	10
11	Allocated from NuCare Services Corp.	2005	1,260	72	20	63	(9)	495	11
12	Allocated from NuCare Services Corp.	2006	1,709	98	20	85	(13)	544	12
13	Allocated from NuCare Services Corp.	2008	1,801	103	20	90	(13)	383	13
14	Allocated from NuCare Services Corp.	2009	28,995	1,656	20	1,450	(206)	5,234	14
15	Allocated from NuCare Services Corp.	2010	4,456	254	20	223	(31)	559	15
16	Allocated from NuCare Services Corp.	2011	241	14	20	12	(2)	23	16
17	Allocated from NuCare Services Corp.	2012	268	15	20	10	(5)	10	17
18									18
19	Allocated from 7257 N. Lincoln Ave, LLC	2004	2,302		20	115	115	978	19
20	Allocated from 7257 N. Lincoln Ave, LLC	2005	10,559	74	20	681	607	4,982	20
21									21
22	Allocated from Clinical Consulting Services	2004	128		20	6	6	54	22
23	Allocated from Clinical Consulting Services	2005	587	4	20	38	34	277	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
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 (12H & 12I lines 1 thru 33)		\$ 196,869	\$ 6,699		\$ 7,382	\$ 683	\$ 55,159	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	\$1,045,599	\$4,196	\$105,368	\$101,172	10	\$711,848	71
72	Current Year Purchases	48,673	854	4,744	3,890	10	4,744	72
73	Fully Depreciated Assets	1,647,639		10	10	10	1,647,637	73
74								74
75	TOTALS	\$2,741,911	\$5,050	\$110,122	\$105,072		\$2,364,229	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	2012	\$792	\$45	\$158	\$113	5	\$383	76
77										77
78										78
79										79
80	TOTALS			\$792	\$45	\$158	\$113		\$383	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)	\$16,044,809	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$514,327	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$752,252	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$237,925	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$12,211,717	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	Land - 2012	\$44,811	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$44,811	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Unit				6,259			5
6	Allocated from Nucare				584			6
7	TOTAL				\$ 6,843			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: \$ 32,094
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	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	\$		\$ 656,702	\$		\$ 656,702	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			183,064			183,064	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			529,920			529,920	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				488,823		488,823	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					11,444	171,391		182,835	13
14	TOTAL			\$		\$ 1,381,130	\$ 660,214		\$ 2,041,344	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	\$ 10,714	\$ 2,126,312	1
2	Cash-Patient Deposits	22,903	22,903	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,293,955	4,293,955	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	183,819	183,819	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	229,486	229,486	8
9	Other(specify): See Attached Schedule	14,893	14,893	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,755,770	\$ 6,871,368	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		899,811	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	3,420,671	3,462,083	15
16	Equipment, at Historical Cost	3,197,271	4,200,751	16
17	Accumulated Depreciation (book methods)	(4,200,830)	(9,068,980)	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	(1,886,888)	5,080,109	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 530,224	\$ 12,572,672	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,285,994	\$ 19,444,040	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,888,295	\$ 2,895,294	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,316	25,316	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	508,832	508,832	30
31	Accrued Taxes Payable (excluding real estate taxes)	88,079	88,079	31
32	Accrued Real Estate Taxes(Sch.IX-B)		537,868	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	5,300	5,300	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,515,822	\$ 4,060,689	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,820,000	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)	\$	\$ 16,820,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,515,822	\$ 20,880,689	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,770,172	\$ (1,436,649)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,285,994	\$ 19,444,040	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,843,206	1
2	Restatements (describe):		2
3	Hazard Restatement	(160,413)	3
4	Mark Berger Buyout	60,000	4
5	Rounding	(2)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,742,791	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	27,381	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)	\$ 27,381	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,770,172	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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,524,784	1
2	Discounts and Allowances for all Levels	(1,044,317)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,480,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,767,760	6
7	Oxygen	14,319	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,782,079	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	626,190	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	160,767	19
20	Radiology and X-Ray	53,907	20
21	Other Medical Services	133,402	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 974,266	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***	2,116	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,126	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,517	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,517	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,241,455	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,249,162	31
32	Health Care	6,225,688	32
33	General Administration	4,660,845	33
	B. Capital Expense		
34	Ownership	2,229,667	34
	C. Ancillary Expense		
35	Special Cost Centers	2,341,676	35
36	Provider Participation Fee	507,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,214,074	40
41	Income before Income Taxes (line 30 minus line 40)**	27,381	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 27,381	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,657,079	44
45	Private Pay - Net Inpatient Revenue	405,878	45
46	Medicare - Net Inpatient Revenue	2,619,451	46
47	Other-(specify) CCHHS	107,483	47
48	Other-(specify) Managed Care, Hospice, Veteran	690,576	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,480,467	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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	4,980	5,823	\$ 191,871	\$ 32.95	1
2	Assistant Director of Nursing	1,690	1,947	71,645	36.80	2
3	Registered Nurses	31,357	33,456	1,164,230	34.80	3
4	Licensed Practical Nurses	63,293	69,582	1,705,278	24.51	4
5	CNAs & Orderlies	160,035	170,363	1,748,735	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,571	7,895	80,999	10.26	8
9	Activity Director	3,366	3,593	56,376	15.69	9
10	Activity Assistants	9,622	10,676	99,608	9.33	10
11	Social Service Workers	8,336	8,940	150,998	16.89	11
12	Dietician	3,632	3,957	78,739	19.90	12
13	Food Service Supervisor					13
14	Head Cook	5,586	5,914	65,141	11.01	14
15	Cook Helpers/Assistants	26,065	28,622	281,457	9.83	15
16	Dishwashers					16
17	Maintenance Workers	4,448	4,686	118,384	25.26	17
18	Housekeepers	195	200	1,759	8.80	18
19	Laundry	154	157	1,378	8.78	19
20	Administrator	2,002	2,091	127,475	60.96	20
21	Assistant Administrator	781	1,025	28,399	27.71	21
22	Other Administrative	211	211	14,617	69.27	22
23	Office Manager					23
24	Clerical	12,078	13,242	289,876	21.89	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	2,645	2,829	41,919	14.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	8,498	9,353	224,036	23.95	33
34	TOTAL (lines 1 - 33)	352,545	384,562	\$ 6,542,920 *	\$ 17.01	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	288	\$ 13,736	01-03	35
36	Medical Director	Monthly	28,800	09-03	36
37	Medical Records Consultant	Monthly	66,200	10-03	37
38	Nurse Consultant	410	8,418	10-03	38
39	Pharmacist Consultant	Monthly	16,778	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	89	5,340	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	787	\$ 139,272		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Renaissance Park South		STATE OF ILLINOIS		Report Period Beginning:		01/01/12		Page 21		
				# 0049098				Ending:		12/31/12		
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		
Rolando Carter	Administrator	0.00%	\$ 127,475	Workers' Compensation Insurance		\$ 241,649		IDPH License Fee		\$ 1,327		
Brent Fitzgerald	Assist. Admin.	0.00%	2,989	Unemployment Compensation Insurance		326,215		Advertising: Employee Recruitment		1,300		
Yolanda Brown	Assist. Admin.	0.00%	25,410	FICA Taxes		481,983		Health Care Worker Background Check				
Sondra Mixdorf	Reg. Dir. Of Operat.	0.00%	14,617	Employee Health Insurance		265,298		(Indicate # of checks performed 682)		15,053		
				Employee Meals		34,496		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*				Dues & Subscriptions		26,669		
				Chicago Head Tax		4,120		Licenses & Inspections		14,293		
TOTAL (agree to Schedule V, line 17, col. 1)				Pension		50,417		Advertising & Promotion		51,555		
(List each licensed administrator separately.)			\$ 170,492	Dental Insurance		5,263		Allocated from Nucare		592		
B. Administrative - Other				Vision Insurance		268		See Supplemental Schedule		114		
Description			Amount	401K Matching Expense		3,793		Less: Public Relations Expense	(		)	
Bookkeeping Fees- NuCare Services			\$ 696,542	Other Employee Benefits		22,099		Non-allowable advertising		(51,555)		
Administrative Fees- Clinical Consulting Services (CCS)			57,362					Yellow page advertising	(		)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 753,905	TOTAL (agree to Schedule V, line 22, col.8)				\$ 1,435,601	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 59,348
(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												
Vendor/Payee	Type		Amount	Description	Line #	Amount		Description		Amount		
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 30,913			\$		Out-of-State Travel		\$		
See Attached	Legal		109,018									
CDW Computers Centers	Computer Services		697									
Curaspan Inc.	Computer Services		5,450					In-State Travel				
Health Data Solutions	Computer Services		2,052									
HDSI	Computer Services		5,876									
On Shift Inc.	Computer Services		17,280									
Optima Healthcare Solutions	Computer Services		693					Seminar Expense		18,116		
PSD Solutions	Computer Services		7,770					Allocated from Nucare		155		
Angela Noland	Mystery Shopping		200					Allocated from CCS		373		
CES Consulting	HR & Payroll Consulting		71									
See Supplemetal Schedule			15,348					Entertainment Expense	(		)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				\$	(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 195,368						TOTAL			\$ 18,644
* Attach copy of IMRF notifications												
SEE ACCOUNTANTS' COMPILATION REPORT												
**See instructions.												

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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. IL Council on LTC \$29,340

(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. \$ 368 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. \$ 507,036
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. \$ 34,496 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

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

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

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