

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0042085

Facility Name: The Renaissance at South Shore

Address: 2425 East 71st Street Chicago 60649
 Number City Zip Code

County: Cook

Telephone Number: (773) 721-5000 **Fax #** (773) 721-6850

HFS ID Number: 363938428001

Date of Initial License for Current Owners: 10/23/98

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Kimberley A. Waite, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	<u>246</u>	Skilled (SNF)	<u>246</u>	<u>89,790</u>	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	<u>246</u>	TOTALS	<u>246</u>	<u>89,790</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>66,408</u>	<u>1,100</u>	<u>17,402</u>	<u>84,910</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,408</u>	<u>1,100</u>	<u>17,402</u>	<u>84,910</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.57%

D. How many bed-hold days during this year were paid by the Department? 2,087 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/23/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 246 and days of care provided 13,408

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number The Renaissance at South Shore # 0042085 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	382,826	96,877	9,051	488,754		488,754		488,754			1
2	Food Purchase		403,271		403,271	(21,900)	381,371	(160)	381,211			2
3	Housekeeping	219,262	61,297		280,559		280,559		280,559			3
4	Laundry	103,802	12,339		116,141		116,141		116,141			4
5	Heat and Other Utilities			235,651	235,651		235,651	(18,529)	217,122			5
6	Maintenance	132,845	33,629	132,306	298,780		298,780	4,477	303,257			6
7	Other (specify):*											7
8	TOTAL General Services	838,735	607,413	377,008	1,823,156	(21,900)	1,801,256	(14,212)	1,787,044			8
	B. Health Care and Programs											
9	Medical Director			32,055	32,055		32,055		32,055			9
10	Nursing and Medical Records	3,953,140	248,873	15,959	4,217,972		4,217,972	(9,020)	4,208,952			10
10a	Therapy			756	756		756		756			10a
11	Activities	205,739	3,702	1,860	211,301		211,301		211,301			11
12	Social Services	144,297		888	145,185		145,185		145,185			12
13	CNA Training											13
14	Program Transportation			2,509	2,509		2,509		2,509			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,303,176	252,575	54,027	4,609,778		4,609,778	(9,020)	4,600,758			16
	C. General Administration											
17	Administrative	286,599		658,442	945,041		945,041	(594,372)	350,669			17
18	Directors Fees											18
19	Professional Services			141,061	141,061	(5,807)	135,254	(53,910)	81,344			19
20	Dues, Fees, Subscriptions & Promotions			86,533	86,533		86,533	(53,503)	33,030			20
21	Clerical & General Office Expenses	358,176	53,575	374,893	786,644		786,644	(175,397)	611,247			21
22	Employee Benefits & Payroll Taxes			985,774	985,774	21,900	1,007,674	(2,000)	1,005,674			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,491	6,491		6,491	265	6,756			24
25	Other Admin. Staff Transportation			1,999	1,999		1,999	440	2,439			25
26	Insurance-Prop.Liab.Malpractice			314,205	314,205		314,205	6,131	320,336			26
27	Other (specify):*							36,655	36,655			27
28	TOTAL General Administration	644,775	53,575	2,569,398	3,267,748	16,093	3,283,841	(835,691)	2,448,150			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,786,686	913,563	3,000,433	9,700,682	(5,807)	9,694,875	(858,923)	8,835,952			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.

Facility Name & ID Number The Renaissance at South Shore

#0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			121,600	121,600		121,600	(32,836)	88,764			30
31	Amortization of Pre-Op. & Org.			7,522	7,522		7,522		7,522			31
32	Interest							1,194	1,194			32
33	Real Estate Taxes			371,460	371,460	5,807	377,267	2,718	379,985			33
34	Rent-Facility & Grounds			1,697,799	1,697,799		1,697,799	541	1,698,340			34
35	Rent-Equipment & Vehicles			16,565	16,565		16,565	3,749	20,314			35
36	Other (specify):*											36
37	TOTAL Ownership			2,214,946	2,214,946	5,807	2,220,753	(24,634)	2,196,119			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	4,079	411,577	631,608	1,047,264		1,047,264		1,047,264			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,685	134,685		134,685		134,685			42
43	Other (specify):*	87,778			87,778		87,778	(87,778)				43
44	TOTAL Special Cost Centers	91,857	411,577	766,293	1,269,727		1,269,727	(87,778)	1,181,949			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,878,543	1,325,140	5,981,672	13,185,355		13,185,355	(971,335)	12,214,020			45

*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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(21,765)	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	(42,832)	30		9
10	Interest and Other Investment Income	(175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(516)	21		18
19	Entertainment	(367)	24		19
20	Contributions	(22,749)	20		20
21	Owner or Key-Man Insurance	(40,792)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(131,651)	21		24
25	Fund Raising, Advertising and Promotional	(26,977)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,819)	20		28
29	Other-Attach Schedule	(338,832)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (629,527)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(341,808)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (341,808)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (971,335)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0042085
 Report Period Beginning: 01/01/05
 Ending: 12/31/05

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Jury Duty	\$ (70)	10	1
2 Food Receipts	(108)	02	2
3 Misc. Income	(3,729)	23	3
4 Patient Needs	(3,249)	10	4
5 Patient Clothing	(5,701)	10	5
6 Bank Charges	(16,711)	23	6
7 Undocumented Professional Fees	(141)	19	7
8 Non-Allowable Legal	(58,467)	19	8
9 COPE Fees	(3,179)	20	9
10 Non-Allowable Expense	(156,100)	21	10
11 Marketing Consultant	(3,930)	19	11
12 Marketing Salaries	(97,778)	43	12
13 Non-Allowable Seminar	(189)	24	13
14 Non-Allowable Expense	(2,572)	21	14
15 Holiday Expense	(2,000)	22	15
16			16
17			17
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96			96
97			97
98			98
99			99
100			100
101 Total	(338,832)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(160)											(160)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(21,765)				3,236							(18,529)	5
6	Maintenance					4,477							4,477	6
7	Other (specify):*													7
8	TOTAL General Services	(21,925)				7,713							(14,212)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,020)											(9,020)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(9,020)											(9,020)	16
	C. General Administration													
17	Administrative			(2,994)	(112,554)	(478,824)							(594,372)	17
18	Directors Fees													18
19	Professional Services	(58,446)		417	455	3,664							(53,910)	19
20	Fees, Subscriptions & Promotions	(55,724)		197		2,024							(53,503)	20
21	Clerical & General Office Expenses	(351,071)		1,353	874	173,447							(175,397)	21
22	Employee Benefits & Payroll Taxes	(2,000)											(2,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(556)		132		689							265	24
25	Other Admin. Staff Transportation					440							440	25
26	Insurance-Prop.Liab.Malpractice					6,131							6,131	26
27	Other (specify):*			2,956	823	32,876							36,655	27
28	TOTAL General Administration	(467,797)		2,061	(110,402)	(259,553)							(835,691)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(498,742)		2,061	(110,402)	(251,840)							(858,923)	29

STATE OF ILLINOIS

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(42,832)				9,996							(32,836)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(175)				1,369							1,194	32
33	Real Estate Taxes					2,718							2,718	33
34	Rent-Facility & Grounds					541							541	34
35	Rent-Equipment & Vehicles					3,749							3,749	35
36	Other (specify):*													36
37	TOTAL Ownership	(43,007)				18,373							(24,634)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(87,778)											(87,778)	43
44	TOTAL Special Cost Centers	(87,778)											(87,778)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(629,527)		2,061	(110,402)	(233,467)							(971,335)	45

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	There Is No Longer Common Ownership Of The Building					
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore# 0042085Report Period Beginning: 01/01/05Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 14,606	\$ 14,606	15
16	V	19 PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		417	417	16
17	V	20 FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		197	197	17
18	V	21 CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		1,353	1,353	18
19	V	24 SEMINARS		CAREPATH HEALTH NETWORK		132	132	19
20	V	27 GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		2,956	2,956	20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	17,600	CAREPATH HEALTH NETWORK			(17,600)	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		\$ 17,600			\$ 19,661	\$ * 2,061	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore# 0042085Report Period Beginning: 01/01/05Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 7,446	\$ 7,446	15
16	V	19 PROFESSIONAL FEES		JLR MANAGEMENT CORP.		455	455	16
17	V	21 OFFICE		JLR MANAGEMENT CORP.		874	874	17
18	V	27 PAYROLL TAXES		JLR MANAGEMENT CORP.		823	823	18
19	V							19
20	V							20
21	V	17 MARVIN NEEDLE-CONS. FEES		JLR MANAGEMENT CORP.				21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V	17 MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.			(120,000)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 120,000			\$ 9,598	\$ * (110,402)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore# 0042085Report Period Beginning: 01/01/05Ending: 12/31/05

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%	\$ 3,236	\$	3,236	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.		4,477		4,477	16
17	V	17 ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.		23,789		23,789	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.		3,664		3,664	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		2,024		2,024	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.		173,447		173,447	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		689		689	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		440		440	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.		6,131		6,131	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		30,285		30,285	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.		9,996		9,996	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.		1,369		1,369	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.		2,718		2,718	27
28	V	34 BUILDING RENT		NUCARE SERVICES CORP.		541		541	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.		3,749		3,749	29
30	V	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.		4,965		4,965	30
31	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.		13,264		13,264	31
32	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.					32
33	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		1,689		1,689	33
34	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		902		902	34
35	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.					35
36	V								36
37	V	17 MANAGEMENT FEES	520,842	NUCARE SERVICES CORP.				(520,842)	37
38	V								38
39	Total		\$ 520,842			\$ 287,375	\$ *	(233,467)	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 COMP	\$ 91,261	DIAMOND INSURANCE	40.00%	\$ 91,261	\$	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			\$ 91,261			\$ 91,261	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending: 12/31/05

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

Facility Name & ID Number The Renaissance at South Shore # 0042085 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Robert Hartman	Owner	Administrative	20.05%	See Attached	1.99	3.98%	Allocated	\$ 4,965	17-7	1
2	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2.00	3.08%				2
3	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	5.00	7.69%	Alloc. JLR	7,445	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,410		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 The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	305,641	9	\$ 253,650	\$ 17,600	\$ 14,606	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	305,641	9	7,234	17,600	417	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	305,641	9	3,415	17,600	197	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	305,641	9	23,496	17,600	1,353	4
5	24	SEMINARS	CARE PATH FEES	305,641	9	2,300	17,600	132	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	305,641	9	51,334	17,600	2,956	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					\$ 341,429	\$ 253,650	\$ 19,661	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	5	\$ 7,446	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		5	455	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	9,614	9,614	5	874	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,055		5	823	4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				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					\$ 141,865	\$ 91,514		\$ 9,598	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 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

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	5	UTILITIES	AVAIL. CENSUS DAYS 904,250	11	\$ 32,587	\$	89,790	\$ 3,236	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 904,250	11	45,083		89,790	4,477	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS 904,250	11	239,568	232,849	89,790	23,789	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 904,250	11	36,902		89,790	3,664	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 904,250	11	20,379		89,790	2,024	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 904,250	11	1,746,738	1,454,049	89,790	173,447	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 904,250	11	6,935		89,790	689	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 904,250	11	4,428		89,790	440	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 904,250	11	61,742		89,790	6,131	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 904,250	11	304,996		89,790	30,285	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 904,250	11	100,669		89,790	9,996	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 904,250	11	13,784		89,790	1,369	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 904,250	11	27,371		89,790	2,718	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS 904,250	11	5,450		89,790	541	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 904,250	11	37,756		89,790	3,749	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 20	11	50,000	50,000	2	4,965	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	11	133,580	133,580	5	13,264	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	4,069	4,069			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 20	11	17,006		2	1,689	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	11	9,079		5	902	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	4,925				21
22									22
23									23
24									24
25	TOTALS				\$ 2,903,047	\$ 1,874,548		\$ 287,375	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 (847) 562-0070

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	22	WORKERS COMP	DIRECT ALLOCATION		\$	\$		\$ 91,261	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				\$	\$		\$ 91,261	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
	Working Capital																
6	Allocated Nuicare Services		X								1,369	6					
7												7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related																
	B. Non-Facility Related*																
10	Interest Income		X								(175)	10					
11												11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related																
15	TOTALS (line 9+line14)																
							\$	\$			1,194	15					

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

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

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.)

Facility Name & ID Number

The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term										7									
Working Capital																				
8						\$	\$			\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2004 report.		\$ <u>373,046</u>	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.)		\$ <u>365,892</u>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>(7,154)</u>	3																																	
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>381,333</u>	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.)		\$ <u>5,807</u>	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 \$ <u>17,569</u> For <u>2001</u> 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.		\$ <u>379,986</u>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td><u>360,670</u></td><td>8</td></tr> <tr><td>2001</td><td><u>385,679</u></td><td>9</td></tr> <tr><td>2002</td><td><u>390,003</u></td><td>10</td></tr> <tr><td>2003</td><td><u>355,282</u></td><td>11</td></tr> <tr><td>2004</td><td><u>363,174</u></td><td>12</td></tr> </table>	2000	<u>360,670</u>	8	2001	<u>385,679</u>	9	2002	<u>390,003</u>	10	2003	<u>355,282</u>	11	2004	<u>363,174</u>	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2000	<u>360,670</u>	8																																		
2001	<u>385,679</u>	9																																		
2002	<u>390,003</u>	10																																		
2003	<u>355,282</u>	11																																		
2004	<u>363,174</u>	12																																		
FOR OHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<u>2005 Accrual = \$363,174 x 1.05 = \$381,333</u>																																				
<u>Allocated Nuicare Services = \$2,283.66</u>																																				
<u>The Accrual used for the 2005 report differs from the 2004 accrual due to an adjustment to R/E taxes at the end of 2004. This adjustment is reflected on the attachment to Page 18.</u>																																				

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Renaissance at South Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-101-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>27,406.92</u>	\$ <u>27,406.92</u>
2. <u>21-30-101-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>51,519.93</u>	\$ <u>51,519.93</u>
3. <u>21-30-101-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>145,377.67</u>	\$ <u>145,377.67</u>
4. <u>21-30-101-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>42,321.92</u>	\$ <u>42,321.92</u>
5. <u>21-30-101-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>96,547.40</u>	\$ <u>96,547.40</u>
6. <u>10-27-319-028</u>	<u>Allocated Nuicare Services</u>	\$ <u>91,772.00</u>	\$ <u>2,283.66</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>454,945.84</u>	\$ <u>365,457.50</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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number The Renaissance at South Shore

0042085 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,865 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: 37,608 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 7,522 4. Dates Incurred: 2002

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	<u>Allocated Nuicare</u>		<u>2004</u>	<u>\$ 7,734</u>	1
2					2
3	TOTALS			\$ 7,734	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1998	78,106		20	3,906	3,906	27,945	9
10	Various			1999	88,720		20	4,438	4,438	29,406	10
11	Various			2000	72,602		20	3,633	3,633	20,566	11
12	Various			2001	45,629		20	2,281	2,281	10,576	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								67
68		103,512	4,640		3,491	(1,149)	6,665	68
69			119,339			(119,339)		69
70		\$ 388,569	\$ 123,979		\$ 17,749	\$ (106,230)	\$ 95,158	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 388,569	\$ 123,979		\$ 17,749	\$ (106,230)	\$ 95,158	1
2	Shades	2002	970		20	97	97	388	2
3	Recircuit Hallways	2002	1,000		20	100	100	383	3
4	Drywall	2002	3,558		20	356	356	1,394	4
5	Parking Lot Sealer	2002	1,661		20	166	166	609	5
6	Drywall - Sandstone	2002	3,396		20	340	340	1,302	6
7	Painting & Decorating	2002	1,172		20	117	117	469	7
8	Sandstone Wall	2003	1,361		20	136	136	397	8
9	Screen Insert	2003	1,183		20	118	118	345	9
10	Network Connections	2003	3,400		20	340	340	963	10
11	Landscaping	2003	900		20	90	90	233	11
12	Mural Painting	2003	750		20	75	75	194	12
13	Wallpaper	2003	1,429		20	143	143	357	13
14	Wallpaper	2003	573		20	57	57	138	14
15	Wanderguard System	2003	2,069		20	207	207	500	15
16	Pleated Shades	2003	616		20	62	62	154	16
17	Pleated Shades	2003	774		20	77	77	181	17
18	Smoke Detectors	2003	1,134		20	113	113	274	18
19	Tiles	2003	668		20	67	67	200	19
20	Painting & Decorating	2003	1,443		20	144	144	433	20
21	Mural	2004	900		20	90	90	165	21
22	Wall Covering	2004	1,576		20	131	131	1,576	22
23	Nbw Timer	2004	758		20	76	76	145	23
24	Freezer Condenser	2004	765		20	77	77	140	24
25	Heater	2004	913		20	91	91	183	25
26	Window	2004	872		20	87	87	131	26
27	Carpeting	2004	2,235		20	319	319	452	27
28	Carpet	2004	2,554		20	365	365	486	28
29	Freezer Condenser	2004	3,525		20	353	353	499	29
30	Awning	2004	8,730		20	873	873	1,237	30
31	Wood Floor	2004	5,708		20	571	571	714	31
32	Cabinets	2004	9,780		20	978	978	1,304	32
33	Parking Lot Repair	2004	1,452		20	145	145	194	33
34	TOTAL (lines 1 thru 33)		\$ 456,394	\$ 123,979		\$ 24,710	\$ (99,269)	\$ 111,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 456,394	\$ 123,979		\$ 24,710	\$ (99,269)	\$ 111,298	1
2	Mirrors	2004	2,400		20	240	240	300	2
3	Smoke Detector	2004	985		20	99	99	131	3
4	Parking Garage Repair	2004	11,200		20	1,120	1,120	1,680	4
5	Time Clock And Stand	2004	3,519		20	352	352	381	5
6	Carpet	2004	2,200		20	220	220	312	6
7	Fire Equip	2004	2,575		20	258	258	365	7
8	Lockers	2005	537		20	45	45	45	8
9	Retaining Wall For Flowers	2005	3,000		20	133	133	133	9
10	Hanging Wallcoverings	2005	1,175		20	783	783	783	10
11	Flooring	2005	1,723		20	29	29	29	11
12	Curtains	2005	1,618		20	13	13	13	12
13	Dishwasher Conveyor Repair	2005	1,115		20	40	40	40	13
14	Fire Alarm Equipment	2005	1,165		20	39	39	39	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)		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12C, Carried Forward		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

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Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549		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)	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12I, Carried Forward		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	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)	\$ 489,606	\$ 123,979		\$ 28,081	\$ (95,898)	\$ 115,549	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated 7257 N. Lincoln Ave, LLC		2004	2004	\$ 69,607	\$ 1,785	35	\$ 1,989	\$ 204	\$ 4,226	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocated Nucares Services Corp			2003	1,163	58	20	58		123	10
11	Allocated Nucares Services Corp			2004	23,614	1,181	20	1,181		2,018	11
12	Allocated Nucares Services Corp			2005	1,400	390	20	35	355	35	12
13											13
14	Allocated 7257 N. Lincoln Ave, LLC			2004	6,345	443	20	159	(284)	159	14
15	Allocated 7257 N. Lincoln Ave, LLC			2005	1,383	783	20	69	(714)	104	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 103,512	\$ 4,640		\$ 3,491	\$ (439)	\$ 6,665	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore # 0042085 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 494,845	\$ 6,738	\$ 53,606	\$ 46,868	10	\$ 269,167	71
72	Current Year Purchases	69,902	880	7,078	6,198	10	7,078	72
73	Fully Depreciated Assets	17,413				10	17,413	73
74								74
75	TOTALS	\$ 582,160	\$ 7,618	\$ 60,684	\$ 53,066		\$ 293,658	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,079,500	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,597	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,765	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (42,832)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 409,207	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: South Shore Limited Partnership

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1998</u>	<u>246</u>		\$ <u>1,691,194</u>			3
4	Additions							4
5	<u>Parking Lot Rental</u>				<u>6,605</u>			5
6	<u>Allocated Nucare Services</u>				<u>541</u>			6
7	TOTAL		246		\$ 1,698,340			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u> </u> /2006	\$ <u> </u>
13.	<u> </u> /2007	\$ <u> </u>
14.	<u> </u> /2008	\$ <u> </u>

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: \$ 20,314 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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	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	\$		\$ 265,445	\$		\$ 265,445	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			77,319			77,319	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			288,844			288,844	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 prescripts				357,027		357,027	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>			4,079			54,550		58,629	13
14	TOTAL			\$ 4,079		\$ 631,608	\$ 411,577		\$ 1,047,264	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

Facility Name & ID Number The Renaissance at South Shore# 0042085Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,856,515		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	133,802		6
7	Other Prepaid Expenses	206,223		7
8	Accounts Receivable (owners or related parties)	120,214		8
9	Other(specify): <u>See Attached Schedule</u>	1,052,935		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,368,789	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,033,365		15
16	Equipment, at Historical Cost	527,652		16
17	Accumulated Depreciation (book methods)	(873,925)		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): <u>See Attached Schedule</u>	262,464		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 949,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,318,345	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,340,902	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,246		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,357		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,354		31
32	Accrued Real Estate Taxes(Sch.IX-B)	381,333		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	36,647		35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	294,298		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,384,137	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,384,137	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,934,208	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,318,345	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,213,918	1
2	Restatements (describe):		2
3	<u>See Attached</u>	246,792	3
4	<u>Rounding</u>	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,460,707	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,473,501	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,473,501	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)	\$ 2,934,208	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,406,684	1
2	Discounts and Allowances for all Levels	(326,817)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,079,867	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,700,698	6
7	Oxygen	225	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,700,923	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	729,708	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,689	19
20	Radiology and X-Ray	10,294	20
21	Other Medical Services	91,724	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 857,415	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	175	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 175	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	20,476	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,476	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,658,856	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,823,156	31
32	Health Care	4,609,778	32
33	General Administration	3,267,748	33
B. Capital Expense			
34	Ownership	2,214,946	34
C. Ancillary Expense			
35	Special Cost Centers	1,135,042	35
36	Provider Participation Fee	134,685	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,185,355	40
41	Income before Income Taxes (line 30 minus line 40)**	1,473,501	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,473,501	43

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

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

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

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/05

Ending:

12/31/05

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,841	2,061	\$ 95,649	\$ 46.41	1
2	Assistant Director of Nursing	1,781	1,927	62,480	32.42	2
3	Registered Nurses	2,485	2,715	610,297	224.79	3
4	Licensed Practical Nurses	56,354	60,508	1,361,396	22.50	4
5	CNAs & Orderlies	152,943	166,729	1,703,391	10.22	5
6	CNA Trainees					6
7	Licensed Therapist	176	176	4,079	23.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,865	4,311	69,626	16.15	9
10	Activity Assistants	13,278	15,165	136,113	8.98	10
11	Social Service Workers	7,284	6,364	144,297	22.67	11
12	Dietician	3,749	4,122	77,001	18.68	12
13	Food Service Supervisor					13
14	Head Cook	7,345	8,024	94,786	11.81	14
15	Cook Helpers/Assistants	24,288	26,460	211,039	7.98	15
16	Dishwashers					16
17	Maintenance Workers	7,312	8,488	132,845	15.65	17
18	Housekeepers	23,768	25,604	219,262	8.56	18
19	Laundry	11,427	12,047	103,802	8.62	19
20	Administrator	1,877	2,086	119,681	57.37	20
21	Assistant Administrator	1,941	2,086	76,371	36.61	21
22	Other Administrative	1,316	1,316	90,547	68.80	22
23	Office Manager					23
24	Clerical	24,860	25,188	358,176	14.22	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	5,309	5,896	119,927	20.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,225	3,378	87,778	25.99	33
34	TOTAL (lines 1 - 33)	356,424	384,651	\$ 5,878,543 *	\$ 15.28	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	212	\$ 9,051	01-03	35
36	Medical Director	Monthly	32,055	09-03	36
37	Medical Records Consultant	4	180	10-03	37
38	Nurse Consultant	280	5,422	10-03	38
39	Pharmacist Consultant	Monthly	4,574	10-03	39
40	Physical Therapy Consultant	10	483	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	273	10a-03	43
44	Activity Consultant	4	1,860	11-03	44
45	Social Service Consultant	3	888	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	519	\$ 54,786		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	177	5,783	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	177	\$ 5,783		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
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. ILCLTC \$13,429.20
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,404 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. \$ 134,685
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. \$ 21,900 Has any meal income been offset against related costs? N/A 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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