

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0049098</u></p> <p><b>Facility Name:</b> <u>The Renaissance at Halsted</u></p> <p><b>Address:</b> <u>10935 South Halsted Street</u> <u>Chicago</u> <u>60628</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 928-2000</u> <b>Fax #</b> <u>(773) 928-9154</u></p> <p><b>HFS ID Number:</b> <u>362877032001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>5/1/1976</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></p>	<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	<b>IRS Exemption Code</b> _____	<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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/07</u> to <u>12/31/07</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4" style="width:15%;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u></td> <td></td> </tr> </table> <p align="center"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 <span style="float:right">Phone # (217) 782-1630</span></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
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SEE ACCOUNTANTS' COMPILATION REPORT

**Date:** 07/01/2007

**To:** Administrator/Cost Report Preparer

**From:** Bureau of Health Finance

**Re:** 2007 Long Term Care Cost Report and Instructions

The 2007 cost report files are now available by download from the Internet or by Email. If you require a disk, please call Fred Sosman at 217-782-1630. The web site for the download of the cost report file and instructions is <http://www.hfs.illinois.gov/costreports/>. Click on the **Long Term Care Long Form** link (the 4th link from the top of the page). Next, right-click on the "Excel version" and select, "Save Target As". Then, save the file on your computer system in the location where you want it. Next, right-click on the instructions file and select "Save Target As". Then, save the file on your computer system.

When you have completed the cost report, **send in the completed cost report file by email, CD or disk. The EMAIL address for requesting the blank Excel form or sending in the completed Excel file is [HFS.HealthFinance@illinois.gov](mailto:HFS.HealthFinance@illinois.gov). A signed paper copy must be sent in also.** *In order to provide for the efficient and accurate processing of any 7/01/08 - 6/30/09 Medicaid rates, the completed Excel cost report file **must be sent in at the same time as the paper copy of the cost report.***

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2007. It is due on September 30, 2007, or 90 days after the close of the facility's fiscal year, **whichever comes later.** Please refer to the instructions for the remainder of the filing requirements.

Please use the 2007 cost report file and instructions. **Printed copies of the report from the 2006 cost report or earlier files will NOT be accepted.** In order to print the instructions on legal paper, open the Instr07.pdf file. Then click File-Page Setup. Change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

**IMPORTANT NOTICE for Those Facilities Receiving a Calendar 2006 Real Estate Tax Bill:** Located after page 10 of the cost report on the worksheet named "RE\_TAX" is the "2006 Long Term Care Real Estate Tax Statement." As in previous years, the real estate tax statement is being included in the cost report. A separate notice requesting the submittal of this statement and the calendar 2006 tax bill will not be sent. Please complete the "2006 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2006 real estate tax bills **as an attachment to the fiscal 2007 cost report.** ***Please Note:*** *Copies of the original tax bills must be provided.*

**If both the "2006 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2007 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.**

#### **Cost Report File**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. **(Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH License ID# is correct.)** **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.**

#### **Attachments**

**Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file.** Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. ***Please do not change or delete the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.***

#### **Page 12 and Pages 12A through 12I**

Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected.

**WARNING:** *Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.*

As you know, save your work frequently to prevent losses of large amounts of information. Print macros have been written that will print each individual page or the entire report.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Bureau of Health Finance. **As part of the filing requirements, send the completed Excel file at the same time you send your paper copy.** Also, please make sure both the completed file and the paper copy agree prior to sending them to our office.

#### **Cost Report File and Extra Pages**

The entire cost report is in one file named Report07.xls. In an Excel file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file.



**Shortcut=**

Hold down  
Control Key and press m



**Shortcut=**

Hold down  
Control Key and press q

**To Stop Macro:**

Hold down  
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE  
ACCOUNTANTS' COMPILATION REPORT"  
AT THE BOTTOM OF EVERY PAGE, ENTER  
THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B  
to print, change cell E11 to zero.

\_\_\_\_\_

Facility Name & ID Number The Renaissance at Halsted

# 0049098 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	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	54,054	2,268	8,097	64,419	8
9	SNF/PED					9
10	ICF	15,785	279	1,192	17,256	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,839	2,547	9,289	81,675	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.59%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 05/01/1976

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 300 and days of care provided 7,400

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number      The Renaissance at Halsted      #      0049098      Report Period Beginning:      01/01/07      Ending:      12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	341,684	87,909	13,988	443,581		443,581	2,675	446,256		1
2	Food Purchase		342,309		342,309	(30,131)	312,178	(106)	312,072		2
3	Housekeeping	184,466	71,950	231,107	487,523		487,523	7,477	495,000		3
4	Laundry	46,320	21,199		67,519		67,519		67,519		4
5	Heat and Other Utilities			277,205	277,205		277,205	3,036	280,241		5
6	Maintenance	146,952	84,170	213,789	444,911		444,911	(26,527)	418,384		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	719,422	607,537	736,089	2,063,048	(30,131)	2,032,917	(13,446)	2,019,472		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			52,560	52,560		52,560		52,560		9
10	Nursing and Medical Records	4,301,399	238,843	279,306	4,819,548		4,819,548	(6,338)	4,813,210		10
10a	Therapy	136,901		3,038	139,939		139,939		139,939		10a
11	Activities	202,391	9,934	2,570	214,895		214,895		214,895		11
12	Social Services	228,840		8,974	237,814		237,814		237,814		12
13	CNA Training										13
14	Program Transportation			1,095	1,095		1,095		1,095		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,869,531	248,777	347,543	5,465,851		5,465,851	(6,338)	5,459,513		16
	<b>C. General Administration</b>										
17	Administrative	132,924			132,924		132,924	90,294	223,218		17
18	Directors Fees										18
19	Professional Services			320,219	320,219	(6,000)	314,219	(97,867)	216,352		19
20	Dues, Fees, Subscriptions & Promotions			168,181	168,181		168,181	(76,790)	91,391		20
21	Clerical & General Office Expenses	273,380	65,917	129,013	468,310		468,310	214,188	682,498		21
22	Employee Benefits & Payroll Taxes			1,134,296	1,134,296	30,131	1,164,427	(54,476)	1,109,951		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,476	6,476		6,476	570	7,046		24
25	Other Admin. Staff Transportation			12,079	12,079		12,079	(6,426)	5,653		25
26	Insurance-Prop.Liab.Malpractice			264,876	264,876		264,876	41,177	306,053		26
27	Other (specify):*							64,907	64,907		27
28	<b>TOTAL General Administration</b>	406,304	65,917	2,035,140	2,507,361	24,131	2,531,492	175,576	2,707,068		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,995,257	922,231	3,118,772	10,036,260	(6,000)	10,030,260	155,793	10,186,053		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 &amp; ID Number

The Renaissance at Halsted

#0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			199,488	199,488		199,488	514,331	713,819			30
31	Amortization of Pre-Op. & Org.							20	20			31
32	Interest			491,851	491,851		491,851	(33,690)	458,161			32
33	Real Estate Taxes					6,000	6,000	577,143	583,143			33
34	Rent-Facility & Grounds			1,047,541	1,047,541		1,047,541	(1,043,858)	3,683			34
35	Rent-Equipment & Vehicles			44,662	44,662		44,662	(2,123)	42,539			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,783,542	1,783,542	6,000	1,789,542	11,823	1,801,365			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	102,592	123,027	675,685	901,304		901,304	(6,123)	895,181			39
40	Barber and Beauty Shops	12,996		345	13,341		13,341	(5,721)	7,620			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	67,865		4,232	72,097		72,097	(72,097)				43
44	<b>TOTAL Special Cost Centers</b>	183,453	123,027	844,512	1,150,992		1,150,992	(83,941)	1,067,051			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	6,178,710	1,045,258	5,746,826	12,970,794		12,970,794	83,674	13,054,468			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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	298,772	30		9
10	Interest and Other Investment Income	(107,359)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(106)	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	(9,867)	20		18
19	Entertainment	(1,887)	24		19
20	Contributions	(12,160)	20		20
21	Owner or Key-Man Insurance	(54,476)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,040)	21		24
25	Fund Raising, Advertising and Promotional	(54,864)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,316)	20		28
29	Other-Attach Schedule	(595,013)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (553,317)		\$	30

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)	636,991		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 636,991		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 83,674		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

**The Renaissance at Halsted**

ID# 0049998  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Office Expense- Building Company	(88)	21 1
2	Accounting Expense- Building Company	(11,500)	19 2
3	Trust Fees- Building Company	(350)	21 3
4	Amortization- Building Company	(3,038)	36 4
5	Bank Charges	(9,501)	21 5
6	Non Allowable Office Expense	(5,567)	21 6
7	Bruncian Income	(5,721)	40 7
8	Pharmacy Expense- Veterans	(6,123)	39 8
9	Patient Needs	(3,216)	10 9
10	Patient Clothing	(2,918)	10 10
11	Interest Paid to Related Parties and Owners	(377,269)	32 11
12	Non-Allowable Depreciation	(8,159)	30 12
13	Non-Allowable Auto Leases	(6,343)	35 13
14	Miscellaneous Income	(1,341)	21 14
15	Jury Duty Income	(120)	10 15
16	Photocopier Income	(80)	21 16
17	Medical Record Receipts	(84)	10 17
18	Marketing Expense	(4,252)	43 18
19	Software	(22,600)	24 19
20	Capitalized R&M	(33,578)	06 20
21	Guest Service Salary	(24,825)	43 21
22	Program Development Salary	(4,617)	43 22
23	Non-Allowable Legal	(6,294)	19 23
24	Non-Allowable Professional Fee	(2,010)	19 24
25	Salary- Collections	(3,173)	43 25
26	Marketing Salary	(38,250)	43 26
27	Marketing Travel	(5,972)	25 27
28	Non-Allowable Travel	(1,244)	25 28
29			29
30			30
31			31
32			32
33			33
34			34
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86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	<b>Total</b>	<b>(595,013)</b>	<b>101</b>

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				2,675								2,675	1
2	Food Purchase	(106)											(106)	2
3	Housekeeping				7,477								7,477	3
4	Laundry													4
5	Heat and Other Utilities				1,420			1,616					3,036	5
6	Maintenance	(33,578)			4,287			2,764					(26,527)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(33,684)</b>			<b>15,859</b>			<b>4,380</b>					<b>(13,446)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(6,338)											(6,338)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(6,338)</b>											<b>(6,338)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,489		38,541	14,136	36,128					90,294	17
18	Directors Fees													18
19	Professional Services	(19,804)	11,500	91	(66,726)	1,163	(32,006)	7,915					(97,867)	19
20	Fees, Subscriptions & Promotions	(79,207)			1,569		27	821					(76,790)	20
21	Clerical & General Office Expenses	(63,367)	438	208	162,944	252	641	113,072					214,188	21
22	Employee Benefits & Payroll Taxes	(54,476)											(54,476)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,887)			1,203			1,254					570	24
25	Other Admin. Staff Transportation	(7,216)						790					(6,426)	25
26	Insurance-Prop.Liab.Malpractice		39,578		652			947					41,177	26
27	Other (specify):*			175	38,454	2,028	2,795	21,455					64,907	27
28	<b>TOTAL General Administration</b>	<b>(225,957)</b>	<b>51,516</b>	<b>1,963</b>	<b>138,096</b>	<b>41,984</b>	<b>(14,407)</b>	<b>182,381</b>					<b>175,576</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(265,979)</b>	<b>51,516</b>	<b>1,963</b>	<b>153,955</b>	<b>41,984</b>	<b>(14,407)</b>	<b>186,761</b>					<b>155,793</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Renaissance at Halsted# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	290,613	207,762		8,159			7,797					514,331	30
31	Amortization of Pre-Op. & Org.				20								20	31
32	Interest	(484,628)	426,569		19,019			5,350					(33,690)	32
33	Real Estate Taxes		566,921		6,773			3,449					577,143	33
34	Rent-Facility & Grounds		(1,044,188)					330					(1,043,858)	34
35	Rent-Equipment & Vehicles	(6,343)			1,719			2,501					(2,123)	35
36	Other (specify):*	(3,038)	3,038											36
37	<b>TOTAL Ownership</b>	<b>(203,396)</b>	<b>160,102</b>		<b>35,690</b>			<b>19,427</b>					<b>11,823</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(6,123)											(6,123)	39
40	Barber and Beauty Shops	(5,721)											(5,721)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(72,097)											(72,097)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(83,941)</b>											<b>(83,941)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(553,317)</b>	<b>211,618</b>	<b>1,963</b>	<b>189,645</b>	<b>41,984</b>	<b>(14,407)</b>	<b>206,188</b>					<b>83,674</b>	<b>45</b>

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		
				Halsted Associates Limited Partnership		Building Co.

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	34 Rent	\$ 1,044,188	Halsted Associates Limited Partnership	100.00%	\$	\$ (1,044,188)	1
2	V	32 Interest	1,359	Halsted Associates Limited Partnership	100.00%		(1,359)	2
3	V	26 Insurance		Halsted Associates Limited Partnership	100.00%	39,578	39,578	3
4	V	21 Office Expense		Halsted Associates Limited Partnership	100.00%	88	88	4
5	V	19 Accounting		Halsted Associates Limited Partnership	100.00%	11,500	11,500	5
6	V	21 Trust Fees		Halsted Associates Limited Partnership	100.00%	350	350	6
7	V	32 Mortgage Interest		Halsted Associates Limited Partnership	100.00%	427,928	427,928	7
8	V	33 Real Estate Taxes		Halsted Associates Limited Partnership	100.00%	566,921	566,921	8
9	V	30 Depreciation		Halsted Associates Limited Partnership	100.00%	207,762	207,762	9
10	V	36 Amortization of Loan Costs		Halsted Associates Limited Partnership	100.00%	3,038	3,038	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,045,547			\$ 1,257,165	\$ * 211,618	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 1,489	\$	1,489	15
16	V	19 PROFESSIONAL FEES				91		91	16
17	V	21 OFFICE				208		208	17
18	V	27 PAYROLL TAXES				175		175	18
19	V								19
20	V	17 C. RAJCHENBACH-COMP.							20
21	V	27 PAYROLL TAXES							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		\$			\$ 1,963	\$ *	1,963	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	17 BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 38,541	\$ 38,541	15
16	V	19 PROFESSIONAL FEES				1,163	1,163	16
17	V	21 OFFICE				252	252	17
18	V	27 PAYROLL TAXES				2,028	2,028	18
19	V							19
20	V							20
21	V							21
22	V	17 MANAGEMENT FEES						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		\$			\$ 41,984	\$ * 41,984	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	1 DIETARY	\$	ITEX / AK CARE COMPANY	100.00%	\$ 2,675	\$	2,675	15
16	V	3 HOUSEKEEPING				7,477		7,477	16
17	V	5 UTILITIES				1,420		1,420	17
18	V	6 REPAIRS AND MAINT.				4,287		4,287	18
19	V	19 PROFESSIONAL FEES				5,274		5,274	19
20	V	20 FEES, SUBSCRIPTIONS				1,569		1,569	20
21	V	21 CLERICAL AND GENERAL				17,937		17,937	21
22	V	24 EDUCATION/SEMINARS				1,203		1,203	22
23	V	26 INSURANCE				652		652	23
24	V	30 DEPRECIATION				8,159		8,159	24
25	V	31 AMORTIZATION				20		20	25
26	V	32 INTEREST				19,019		19,019	26
27	V	33 REAL ESTATE TAXES				6,773		6,773	27
28	V	35 EQUIPMENT RENTAL				1,719		1,719	28
29	V								29
30	V								30
31	V								31
32	V	21 CLERICAL SALARIES				145,007		145,007	32
33	V	27 GEN ADMIN. - EMP. BEN.				38,454		38,454	33
34	V								34
35	V								35
36	V	19 ACCOUNTING/BOOKKEEPING	72,000					(72,000)	36
37	V								37
38	V								38
39	Total		\$ 72,000			\$ 261,645	\$ *	189,645	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	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 14,136	\$ 14,136
16	V	19 PROFESSIONAL FEES				(212)	(212)
17	V	20 DUES AND SUBSCRIPRTIONS				27	27
18	V	21 CLERICAL AND GENERAL				641	641
19	V	27 GEN ADMIN.- EMP. BEN.				2,795	2,795
20	V						
21	V						
22	V						
23	V						
24	V	19 NETWORK FEES	31,794				(31,794)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 31,794			\$ 17,387	\$ * (14,407)

\* 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	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 1,616	\$	1,616	15
16	V	6 REPAIRS AND MAINT.				2,764		2,764	16
17	V	17 ADMIN. - NON-OWNER				19,918		19,918	17
18	V	19 PROFESSIONAL FEES				7,915		7,915	18
19	V	20 FEES SUBSCRIPTIONS				821		821	19
20	V	21 CLERICAL & GENERAL				113,072		113,072	20
21	V	24 SEMINARS AND EDUCATION				1,254		1,254	21
22	V	25 ADMIN. STAFF TRAVEL				790		790	22
23	V	26 INSURANCE				947		947	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.				15,197		15,197	24
25	V	30 DEPRECIATION				7,797		7,797	25
26	V	32 INTEREST EXPENSE				5,350		5,350	26
27	V	33 REAL ESTATE TAX				3,449		3,449	27
28	V	34 PARKING LOT RENT				330		330	28
29	V	35 EQUIPMENT RENTAL				2,501		2,501	29
30	V	17 ADMIN. - R. HARTMAN				10,347		10,347	30
31	V	17 ADMIN. - B. CARR				5,863		5,863	31
32	V	17 ADMIN. - D. HARTMAN							32
33	V	27 EMP. BEN. - R. HARTMAN				5,034		5,034	33
34	V	27 EMP. BEN. - B. CARR				1,224		1,224	34
35	V	27 EMP. BEN. - D. HARTMAN							35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 206,188	\$ *	206,188	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	22 Workers Compensation	\$ 109,803	Diamond Insurance	40.00%	\$ 109,803	\$	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		\$ 109,803			\$ 109,803	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	Mark Hollander	Relative	Administrative	0.00%	See Attached	10.00	16.67%	Salary	\$ 27,000	17-1	1
2	Bernard Hollander	Relative	Administrative	0.00%	See Attached	10.00	15.38%	Alloc. Salary	38,541	17-7	2
3	Jack Rajchenbach	Shareholder	Administrative	21.00%	See Attached	1.00	1.54%	Alloc. Salary	1,489	17-7	3
4	Robert Hartman	Shareholder	Administrative	20.00%	See Attached	0.57	1.14%	Alloc. Salary	10,347	17-7	4
5	Gerry Jenich	Shareholder	Administrative	7.50%	See Attached	2.30	5.75%	Salary	10,347	17-3	5
6	Mark Berger	Shareholder	Administrative	9.00%	See Attached	20.00	50.00%				6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,724		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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 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

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	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	1	\$ 1,489	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		1	91	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,414	11,414	1	208	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,634		1	175	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	59,667	59,667			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,736				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					\$ 172,351	\$ 152,981		\$ 1,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 ITEX / AK CARE COMPANY  
 Street Address 6633 N. LINCOLN AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 679-9141  
 Fax Number ( 847) 679-1820

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	412,656	5	\$ 20,328	\$ 54,300	\$ 2,675	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	412,656	5	56,825	54,300	7,477	2
3	5	UTILITIES	AVAILABLE BED DAYS	412,656	5	10,791	54,300	1,420	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	412,656	5	32,579	54,300	4,287	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	412,656	5	40,078	54,300	5,274	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	412,656	5	11,921	54,300	1,569	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	412,656	5	136,311	54,300	17,937	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	412,656	5	9,145	54,300	1,203	8
9	26	INSURANCE	AVAILABLE BED DAYS	412,656	5	4,952	54,300	652	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	412,656	5	62,006	54,300	8,159	10
11	31	AMORTIZATION	AVAILABLE BED DAYS	412,656	5	152	54,300	20	11
12	32	INTEREST	AVAILABLE BED DAYS	412,656	5	144,533	54,300	19,019	12
13	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	412,656	5	51,475	54,300	6,773	13
14	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	412,656	5	13,061	54,300	1,719	14
15									15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	1,004,580	1,004,580	145,007	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	266,404		38,454	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,865,141	\$ 1,004,580	\$ 261,645	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

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	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	43	5	\$ 165,728	\$ 165,728	10	\$ 38,541	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	43	5	5,000		10	1,163	2
3	21	OFFICE	AVG. HOURS WORKED	43	5	1,083	1,083	10	252	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	43	5	8,721		10	2,028	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					\$ 180,532	\$ 166,811		\$ 41,984	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	CARE PATH FEES	388,800	9	\$ 175,237	\$ 175,237	31,363	\$ 14,136	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	388,800	9	(2,628)	31,363	(212)		2
3	20	DUES AND SUBSCRIPTRIONS	CARE PATH FEES	388,800	9	332	31,363	27		3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	388,800	9	7,946	31,363	641		4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	388,800	9	34,646	31,363	2,795		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					\$ 215,533	\$ 175,237		\$ 17,387	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	960,286	12	\$ 28,115	\$ 55,200	\$ 1,616	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	960,286	12	48,079	55,200	2,764	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	960,286	12	346,499	346,499	19,918	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	960,286	12	137,702	55,200	7,915	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	960,286	12	14,277	55,200	821	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	960,286	12	1,967,057	1,688,717	113,072	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	960,286	12	21,810	55,200	1,254	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	960,286	12	13,739	55,200	790	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	960,286	12	16,477	55,200	947	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	960,286	12	264,372	55,200	15,197	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	960,286	12	135,649	55,200	7,797	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	960,286	12	93,063	55,200	5,350	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	960,286	12	60,000	55,200	3,449	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	960,286	12	5,749	55,200	330	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	960,286	12	43,501	55,200	2,501	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	10	12	180,000	180,000	10,347	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED	50	12	102,000	102,000	5,863	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	40	2	80,000	80,000	-	18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	10	12	87,577	0.57	5,034	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	50	12	21,286	2.87	1,224	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	40	2	16,421	-	-	21
22									22
23									23
24									24
25	TOTALS					\$ 3,683,372	\$ 2,397,215	\$ 206,188	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Diamond Insurance  
 Street Address 40 Skokie Blvd, Suite 105  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number ( 847) 559-1002  
 Fax Number ( )

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation		\$	\$		\$ 109,803	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				\$	\$		\$ 109,803	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted

# 0049098 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending: 12/31/07

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cambridge		X	Mortgage	\$43,906.00	07/01/03	\$ 8,276,700	\$ 7,879,005	07/01/2038	5.4000	\$ 427,928	1								
2	Hill Rom/TCF Leasing		X	Video Equipment							11	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Bank Leiumi		X	Line Of Credit				2,065,000			114,226	6								
7	Due to Owners/Related Party	X		Working Capital				1,827,268			377,270	7								
8	See Supplemental Schedule										24,713	8								
9	TOTAL Facility Related				\$43,906.00		\$ 8,276,700	\$ 11,771,273			\$ 944,148	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(107,359)	10								
11	Interest Income- Bldg Co		X								(1,359)	11								
12	Owners Interest	X									(377,270)	12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (485,988)	14								
15	TOTALS (line 9+line14)						\$ 8,276,700	\$ 11,771,273			\$ 458,160	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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
6																				
7	<b>TOTAL Long-Term</b>																			
<b>Working Capital</b>																				
8	Allocated From Nucare		X							5,350										
9	Allocated From ITEX		X							19,019										
10	A.L. Credit		X	Insurance Financing						344										
11																				
12																				
13																				
14	<b>TOTAL Working Capital</b>									24,713										
<b>B. Non-Facility Related*</b>																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTAL Non-Facility Related</b>																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>290,769</b>	<b>1</b>
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.)		\$	<b>400,082</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>109,313</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>467,831</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>6,000</b>	<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>583,144</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>266,212</b>	<b>8</b>
	2003	<b>268,268</b>	<b>9</b>
	2004	<b>274,197</b>	<b>10</b>
	2005	<b>276,923</b>	<b>11</b>
	2006	<b>389,860</b>	<b>12</b>

**2007 Accrual= \$389,860 X 1.20 = \$467,831 (Rounded)**

**Allocated From ITEX- \$6,773**

**Allocated From NuCare- \$3,449**

	<b>FOR BHF USE ONLY</b>	
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006 \$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Renaissance at Halsted COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049098

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 2006 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 2006.

(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>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>37,176.17</u>	\$ <u>37,176.17</u>
2. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>38,256.97</u>	\$ <u>38,256.97</u>
3. <u>25-16-332-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>127,505.14</u>	\$ <u>127,505.14</u>
4. <u>25-16-332-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>186,921.29</u>	\$ <u>186,921.29</u>
5. <u>10-27-319-028-0000</u>	<u>Home Office Allocation (NuCare)</u>	\$ <u>100,273.68</u>	\$ <u>5,764.02</u>
6. <u>10-35-312-022-0000</u>	<u>Home Office Allocation (ITEX)</u>	\$ <u>53,843.93</u>	\$ <u>6,773.39</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>543,977.18</u>	\$ <u>402,396.98</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME The Renaissance at Halsted COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049098

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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 3

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: 20 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>855,000</u>	<u>1</u>
2	<u>Allocated From 7257 N. Lincoln Ave.</u>		<u>2004</u>	<u>9,197</u>	<u>2</u>
3	<b>TOTALS</b>			\$ <u>864,197</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1978		750		20			750	9
10	Various		1979		12,807		20			12,749	10
11	Various		1980		35,915		20			35,915	11
12	Various		1981		13,910		20			13,910	12
13	Various		1982		8,814		20			8,814	13
14	Various		1983		12,936		20			12,936	14
15	Various		1984		20,560		20			20,560	15
16	Various		1985		18,883		20			18,874	16
17	Various		1986		2,456		20			2,456	17
18	Various		1987		4,000		20	127	127	2,591	18
19	Various		1988		82,596		20	2,621	2,621	50,386	19
20	Various		1989		1,225		20	39	39	716	20
21	Various		1990		91,597		20	3,783	3,783	60,156	21
22	Various		1993		53,620		20	2,681	2,681	41,923	22
23	Various		1995		137,959		20	6,734	6,734	86,585	23
24	Various		1996		538,107		20	26,904	26,904	324,606	24
25	Various		1997		76,548		20	3,842	3,842	41,283	25
26	Various		1998		77,488		20	3,874	3,874	36,865	26
27	Various		1999		278,572		20	13,996	13,996	122,976	27
28	Various		2000		48,393		20	2,247	2,247	17,275	28
29	Various		2001		97,460		20	4,936	4,936	31,132	29
30	Various		2002		25,280		20	2,607	2,607	15,447	30
31	Various		2003		461,688		20	39,227	39,227	177,054	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building 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	Related Building Company (Pages 12-BLDG & 12A-BLDG)	8,043,269	207,761		402,164	194,403	5,373,349	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	108,218	3,873		3,748	(125)	14,037	68
69	Financial Statement Depreciation		199,488			(199,488)		69
70	TOTAL (lines 4 thru 69)	\$ 10,253,051	\$ 411,122		\$ 519,530	\$ 108,408	\$ 6,523,345	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 10,253,051	\$ 411,122		\$ 519,530	\$ 108,408	\$ 6,523,345	1
2	Wiring	2004	1,194		20	119	119	478	2
3	Electric Installation	2004	6,090		20	609	609	2,436	3
4	Cables And Wiring	2004	2,100		20	210	210	718	4
5	Air Conditioning	2004	3,806		20	381	381	1,237	5
6	Air Conditioners	2004	4,046		20	809	809	2,900	6
7	Pipes And Electrical	2004	4,950		20	990	990	3,300	7
8	Room Fixtures And Outlets	2004	1,165		20	233	233	932	8
9	Flooring	2004	9,400		20	1,880	1,880	7,520	9
10	Painting And Kitchen Installation	2004	2,425		20	485	485	1,940	10
11	Wall Covering	2004	7,763		20	1,553	1,553	5,952	11
12	Bathroom Sewer Line Repair	2004	4,800		20	480	480	1,780	12
13	Paint	2004	990		20	99	99	396	13
14	Water Valve And Circulating Pump	2004	1,282		20	128	128	438	14
15	Hvac	2004	986		20	99	99	345	15
16	Roof Repair	2004	1,820		20	182	182	652	16
17	Roof Repair	2004	2,252		20	225	225	826	17
18	Wallpaper	2004	950		20	95	95	356	18
19	Heater Pump	2004	653		20	65	65	250	19
20	Sprinkler Heads	2004	938		20	94	94	375	20
21	Insulation	2004	2,198		20	220	220	696	21
22	Roof Repair	2004	817		20	82	82	252	22
23	Walk-In Cooler Repair	2004	945		20	95	95	291	23
24	Paint	2004	576		20	58	58	178	24
25	Plastered Walls	2005	7,100		20			7,100	25
26	Plastered Walls	2005	12,700		20			12,700	26
27	Sign	2005	5,615		20	561	561	1,404	27
28	Signs	2005	13,217		20	1,322	1,322	3,084	28
29	Wallpaper	2005	3,288		20	658	658	1,754	29
30	Wallpaper	2005	8,984		20	1,797	1,797	4,193	30
31	Window Treatments	2005	10,661		20	2,132	2,132	4,797	31
32	Wallcovering	2005	337		20	67	67	157	32
33	Blinds	2005	373		20	37	37	81	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,377,472	\$ 411,122		\$ 535,295	\$ 124,173	\$ 6,592,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 10,377,472	\$ 411,122		\$ 535,295	\$ 124,173	\$ 6,592,863	1
2	Floor Covering	2005	48,040		20	3,203	3,203	7,473	2
3	Doors	2005	3,245		20	649	649	1,568	3
4	Doors	2005	5,550		20	1,110	1,110	2,683	4
5	Exhaust Fan	2005	7,912		20	1,582	1,582	3,956	5
6	Closets	2005	6,300		20	630	630	1,418	6
7	Phone System	2005	7,130		20	713	713	2,080	7
8	Phone System	2005	4,170		20	417	417	1,008	8
9	Security System	2005	5,738		20	820	820	1,913	9
10	Boiler	2005	2,489		20	207	207	484	10
11	Walk- In Cooler	2005	3,585		20	512	512	1,323	11
12	Walk-In Cooler	2005	4,963		20	709	709	1,832	12
13	Electrical Work	2005	6,800		20	680	680	1,530	13
14	Water Heater	2005	6,377		20	531	531	1,594	14
15	Roofing	2005	3,000		20	300	300	625	15
16	Flooring Adjustment	2005	(95,245)		20	(6,350)	(6,350)	(19,049)	16
17	Door	2005	1,544		20	347	347	347	17
18	Fixture Installation	2005	1,514		20	328	328	328	18
19	Roof Top Unit Repair	2005	3,479		20	725	725	725	19
20	Chiller Fan Repair	2005	2,359		20	511	511	511	20
21	Roof Top Units & Heat Exchanger	2005	2,910		20	145	145	303	21
22	Installing 58 Outlets	2006	15,000		20	1,500	1,500	2,250	22
23	Gerber Toilet And Tank	2006	1,700		20	340	340	680	23
24	New Rooftop Exhaust Fan	2006	2,124		20	425	425	672	24
25	Wallpaper Lounge And Resident Rooms	2006	4,033		20	807	807	1,479	25
26	Carpeting	2006	1,836		20	184	184	321	26
27	Pinch Pleated Draperies	2006	1,913		20	383	383	574	27
28	Elevator Shaft Smoke Detector And Recalls	2006	11,890		20	1,189	1,189	1,585	28
29	Sprinkler System Head Replacements	2006	11,766		20	1,177	1,177	1,569	29
30	Central Ac Unit Repair	2006	4,108		20	822	822	1,301	30
31	Chiller Repair	2006	5,237		20	1,047	1,047	1,571	31
32	2 Motorized Smoke Dampers	2006	1,400		20	280	280	420	32
33	40 Ton Chiller Replacement	2006	39,020		20	7,804	7,804	11,706	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,509,359	\$ 411,122		\$ 559,022	\$ 147,900	\$ 6,629,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 10,509,359	\$ 411,122		\$ 559,022	\$ 147,900	\$ 6,629,643	1
2	Emergency Work 2 Boilers Out	2006	6,233		20	1,247	1,247	2,389	2
3	Switches	2006	2,430		20	486	486	850	3
4	Perimeter Heating Pump Replacement	2006	3,635		20	727	727	1,272	4
5	Concrete Handicap Ramp	2006	1,800		20	180	180	270	5
6	Telephone System	2007	840		20	84	84	84	6
7	Headend & Cable Hardware	2007	11,000		20	2,017	2,017	2,017	7
8	Unibody Valve	2007	5,225		20	218	218	218	8
9	Water Boiler	2007	8,426		20	527	527	527	9
10	Exhaust Fan	2007	1,465		20	195	195	195	10
11	Satellite America Security Camera	2007	12,375		20	884	884	884	11
12	Keypads; Tv'S; Cameras	2007	5,460		20	455	455	455	12
13	Electric Booster Heater	2007	3,234		20	81	81	81	13
14	Roof Replacement	2007	54,250		20	1,130	1,130	1,130	14
15	Extend Fire Escape Stairway Railing With Iron Tubes And Weld	2007	3,500		20	73	73	73	15
16	Painting Job	2007	20,000		20	417	417	417	16
17	Wiring Installation For 3Rd Floor - Keypads; Tvs; Cameras; Arm	2007	9,505		20	198	198	198	17
18	Cameras; Buzzer; Dvr; Tv Monitor; Power Supply	2007	3,215		20	67	67	67	18
19	Furnish/Install Keypads	2007	11,220		20	234	234	234	19
20	Electrical Outlets	2007	1,280		20	21	21	21	20
21	Central Processor	2007	4,330		20	72	72	72	21
22	Wanderguard System	2007	5,502		20	131	131	131	22
23	3Rd Floor Bathroom Renovation	2007	9,800		20	123	123	123	23
24	3Rd Floor Bathroom Renovation	2007	2,626		20	33	33	33	24
25	2 Security Cameras	2007	700		20	25	25	25	25
26	3 Security Cameras	2007	1,050		20	38	38	38	26
27	Wiring	2007	1,280		20	16	16	16	27
28	Evap Cooler Water Supply	2007	3,661		20	92	92	92	28
29	Roof	2007	62,350		20	520	520	520	29
30	Landscaping	2007	22,780		20	1,139	1,139	1,139	30
31	Roof	2007	2,500		20	125	125	125	31
32	Bathroom Repairs	2007	2,700		20	135	135	135	32
33	Doors	2007	4,598		20	230	230	230	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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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)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	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
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18								18
19								19
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21								21
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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)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704
2							
3							
4							
5							
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30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
3								3
4								4
5								5
6								6
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8								8
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
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4								4
5								5
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29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
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10								10
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
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28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
3								3
4								4
5								5
6								6
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2								2
3								3
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5								5
6								6
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30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704
2							
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31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	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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15								15
16								16
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704
2							
3							
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5							
6							
7							
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28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 10,798,329	\$ 411,122		\$ 570,942	\$ 159,820	\$ 6,643,704

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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	300	1994	1976	\$ 7,334,294	\$ 188,059	39	\$ 366,715	\$ 178,656	\$ 5,103,450	4
5		1994	1994	554,636	14,221	39	27,732	13,511	191,394	5
6		1994	1994	3,020	77	39	151	74	1,033	6
7		1994	1994	106,949	2,742	39	5,347	2,605	38,047	7
8										8
<b>Improvement Type**</b>										
9	Landscaping	1994	1994	25,996	1,560	20	1,300	(260)	22,878	9
10	Sprinkler System	1994	1994	8,900	534	20	445	(89)	7,832	10
11	Sign - Awning	1994	1994	9,474	568	20	474	(94)	8,715	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
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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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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
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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	<b>TOTAL (lines 4 thru 69)</b>		\$ 8,043,269	\$ 207,761		\$ 402,164	\$ 194,403	\$ 5,373,349	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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated From 7257 N. Lincoln Ave	2004	2004	\$ 82,775	\$ 2,122	35	\$ 2,365	\$ 243	\$ 9,756	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Allocated From NuCare		2003	673	25	20	34	9	139	9
10	Allocated From NuCare		2004	13,670	499	20	684	185	2,538	10
11	Allocated From NuCare		2005	810	30	20	41	11	116	11
12	Allocated From NuCare		2006	1,099	40	20	55	15	75	12
13	Allocated From 7257 N. Lincoln Ave		2005	7,546	968	20	487	(481)	1,125	13
14	Allocated From 7257 N. Lincoln Ave		2004	1,645	189	20	82	(107)	288	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
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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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 108,218	\$ 3,873		\$ 3,748	\$ (125)	\$ 14,037	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 Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 995,467	\$ 3,605	\$ 130,827	\$ 127,222	10	\$ 728,292	71
72	Current Year Purchases	96,192	319	12,004	11,685	10	12,004	72
73	Fully Depreciated Assets	1,878,480		45	45	10	1,878,480	73
74								74
75	TOTALS	\$ 2,970,139	\$ 3,924	\$ 142,876	\$ 138,952		\$ 2,618,776	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)	\$ 14,632,665	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 415,046	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 713,818	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 298,772	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,262,480	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: N/A

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	Storage Unit			3,353			5
6	Parking Lot- Allocated From Nucare			330			6
7	TOTAL			\$ 3,683			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 38,176 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	Facility	2004 Acura	\$ 340.00	\$ 4,363	17
18					18
19					19
20					20
21	TOTAL		\$ 340.00	\$ 4,363	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost													
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 102,592											\$ 102,592	1	
2	Licensed Speech and Language Development Therapist		hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs					416,101		99					416,200		4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	39 - 03	# of prescripts					256,021		23,661					279,682		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>							3,563		99,267					102,830		13
14	<b>TOTAL</b>			\$ 102,592				\$ 675,685		\$ 123,027				\$ 901,304			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 &amp; ID Number    The Renaissance at Halsted

#    0049098

Report Period Beginning:    01/01/07

Ending:    12/31/07

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of    12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 90,729	\$ 142,617	1
2	Cash-Patient Deposits	1,500	1,500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,990,584	2,990,584	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,848	157,513	6
7	Other Prepaid Expenses	1,879	1,879	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>	443,515	823,275	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,666,055	\$ 4,117,368	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	1,948,355	1,992,725	15
16	Equipment, at Historical Cost	2,611,199	3,507,367	16
17	Accumulated Depreciation (book methods)	(2,897,525)	(6,672,908)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		106,330	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(13,671)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	2,444,511	2,444,511	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,106,540	\$ 10,218,252	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,772,595	\$ 14,335,620	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,590,190	\$ 1,590,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,892,268	3,892,268	29
30	Accrued Salaries Payable	303,188	303,188	30
31	Accrued Taxes Payable (excluding real estate taxes)	90,295	90,295	31
32	Accrued Real Estate Taxes(Sch.IX-B)		467,831	32
33	Accrued Interest Payable		35,456	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	24,114	24,114	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	4,609,541	4,619,041	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 10,509,596	\$ 11,022,384	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,879,005	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 7,879,005	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 10,509,596	\$ 18,901,389	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,737,001)	\$ (4,565,769)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,772,595	\$ 14,335,620	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,865,009)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding Adjustment</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,865,006)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,128,005</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,128,005</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,737,001)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted# 0049098Report Period Beginning: 01/01/07Ending: 12/31/07**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 10,456,265	1
2	Discounts and Allowances for all Levels	(544,849)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,911,416	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,169,884	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,169,884	8
	<b>C. Other Operating Revenue</b>		
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	5,721	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,575	19
20	Radiology and X-Ray	2,660	20
21	Other Medical Services	44,112	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 416,456	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	107,359	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 107,359	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	2,493,684	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,493,684	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,098,799	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,063,048	31
32	Health Care	5,465,851	32
33	General Administration	2,507,361	33
	<b>B. Capital Expense</b>		
34	Ownership	1,783,542	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	986,742	35
36	Provider Participation Fee	164,250	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,970,794	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,128,005	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,128,005	43

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

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

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

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

Facility Name & ID Number The Renaissance at Halsted

# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	1,688	1,774	\$ 85,803	\$ 48.37	1
2	Assistant Director of Nursing	927	975	29,196	29.94	2
3	Registered Nurses	22,141	24,797	726,295	29.29	3
4	Licensed Practical Nurses	66,634	72,220	1,757,110	24.33	4
5	CNAs & Orderlies	160,614	173,697	1,652,193	9.51	5
6	CNA Trainees					6
7	Licensed Therapist	3,728	4,028	102,592	25.47	7
8	Rehab/Therapy Aides	4,517	5,076	136,901	26.97	8
9	Activity Director	2,634	2,911	43,664	15.00	9
10	Activity Assistants	17,177	18,874	158,727	8.41	10
11	Social Service Workers	12,264	13,463	228,840	17.00	11
12	Dietician	1,422	1,666	22,889	13.74	12
13	Food Service Supervisor					13
14	Head Cook	625	684	6,312	9.23	14
15	Cook Helpers/Assistants	31,723	34,720	312,483	9.00	15
16	Dishwashers					16
17	Maintenance Workers	9,368	10,079	146,952	14.58	17
18	Housekeepers	17,555	19,372	184,466	9.52	18
19	Laundry	4,824	5,801	46,320	7.98	19
20	Administrator	683	726	39,058	53.80	20
21	Assistant Administrator	653	686	73,356	106.93	21
22	Other Administrative	2,829	2,928	20,510	7.00	22
23	Office Manager					23
24	Clerical	28,308	28,940	273,380	9.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,342	2,682	50,802	18.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,916	5,010	80,860	16.14	33
34	TOTAL (lines 1 - 33)	397,572	431,109	\$ 6,178,709 *	\$ 14.33	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	374	\$ 13,988	01-03	35
36	Medical Director	Monthly	52,560	09-03	36
37	Medical Records Consultant	Monthly	4,928	10-03	37
38	Nurse Consultant	Monthly	72,951	10-03	38
39	Pharmacist Consultant	Monthly	2,965	10-03	39
40	Physical Therapy Consultant	2	100	10a-03	40
41	Occupational Therapy Consultant	39	2,718	10a-03	41
42	Respiratory Therapy Consultant	10	220	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,570	11-03	44
45	Social Service Consultant	160	8,974	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	634	\$ 161,974		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	564	\$ 35,871	10-03	50
51	Licensed Practical Nurses	4,164	162,591	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,728	\$ 198,462		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Theodore O'Brien	Administrator	0%	\$ 33,143	Workers' Compensation Insurance	\$ 109,803	IDPH License Fee	\$ 498		
Vanessa Davenport	Asst. Admin.	0%	19,645	Unemployment Compensation Insurance	180,051	Advertising: Employee Recruitment	56,906		
Kathleen Brander	Dir. Reg Mgmt	0%	5,867	FICA Taxes	446,324	Health Care Worker Background Check	5,726		
Marilyn Flaherty	VP MC Reimb.	0%	7,985	Employee Health Insurance	252,174	(Indicate # of checks performed <u>573</u> )			
Jennifer Bebinger	Alzheim. Director	0%	176	Employee Meals	30,131	Patient Background Checks			
Gerry Jenich	CEO	0%	10,347	Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	21,229		
See Supplemental Schedule			55,761	Chicago Head Tax	12,521	Advertising and Promotions	57,180		
TOTAL (agree to Schedule V, line 17, col. 1)				Union Pension	41,085	Licenses and Fees	4,614		
(List each licensed administrator separately.)			\$ 132,924	Dental Insurance	1,948	Allocated From ITEX	1,569		
				Other Employee Benefits	35,914	See Supplemental Schedule	848		
<b>B. Administrative - Other</b>							Less: Public Relations Expense		(23,378)
Description			Amount				Non-allowable advertising		(31,485)
			\$				Yellow page advertising		(2,316)
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 91,391
				TOTAL (agree to Schedule V, line 22, col.8)					\$ 1,109,951
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
CuraSpan	Computer Services		\$ 2,200			\$	Out-of-State Travel	\$	
Emdeon	Revenue Cycle Consult		188						
GiftRap	Computer Consulting		6,948						
HDSI	Data Processing		5,386				In-State Travel		
Ivans	Computer Consulting		653						
Medifax	Medical Transcription		951						
PSD Solutions	Computer Consulting		6,958				Seminar Expense	4,589	
IIT Source Tech	Computer Consulting		675				Allocated From ITEX	1,203	
Frost, Ruttenberg & Rothblatt	Accounting		4,269				Allocated From NuCare	1,254	
Honkamp Krueger	Accounting		2,834						
AK Care	Accounting/Bookkeeping		72,000				Entertainment Expense	( )	
See Supplemental Schedule			217,157				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 7,046	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 320,219						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at Halsted# 0049098

Report Period Beginning:

01/01/07

Ending:

12/31/07**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. ICLTC \$14,130 IL Assoc. HC \$3,600
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 65,394 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. \$ 164,250  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 30,131 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
- 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees