

Facility Name & ID Number The Renaissance at South Shore

0042085 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			<u>14,045</u>	<u>14,045</u>	8
9	SNF/PED					9
10	ICF	<u>64,590</u>	<u>2,310</u>	<u>4,138</u>	<u>71,038</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>64,590</u>	<u>2,310</u>	<u>18,183</u>	<u>85,083</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.99%

D. How many bed-hold days during this year were paid by the Department? 274 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/23/1998

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 248 and days of care provided 12,924

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number The Renaissance at South Shore # 0042085 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	433,882	102,536	11,911	548,329		548,329		548,329		1
2	Food Purchase		447,066		447,066	(24,236)	422,830	(1,059)	421,771		2
3	Housekeeping	246,462	64,501	144	311,107		311,107		311,107		3
4	Laundry	143,621	35,991		179,612		179,612		179,612		4
5	Heat and Other Utilities			185,817	185,817		185,817	(3,648)	182,169		5
6	Maintenance	127,293	96,659	197,745	421,697		421,697	28,138	449,835		6
7	Other (specify):*										7
8	TOTAL General Services	951,258	746,753	395,617	2,093,628	(24,236)	2,069,392	23,431	2,092,823		8
	B. Health Care and Programs										
9	Medical Director			84,342	84,342		84,342		84,342		9
10	Nursing and Medical Records	4,746,854	501,764	20,561	5,269,179		5,269,179	13,645	5,282,824		10
10a	Therapy	198,905			198,905		198,905		198,905		10a
11	Activities	232,014	20,072	1,513	253,599		253,599		253,599		11
12	Social Services	153,599		1,004	154,603		154,603		154,603		12
13	CNA Training										13
14	Program Transportation			3,802	3,802		3,802	(12)	3,790		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,331,372	521,836	111,222	5,964,430		5,964,430	13,633	5,978,063		16
	C. General Administration										
17	Administrative	169,045		918,891	1,087,936		1,087,936	(885,939)	201,997		17
18	Directors Fees										18
19	Professional Services			111,400	111,400	(497)	110,903	(12,552)	98,351		19
20	Dues, Fees, Subscriptions & Promotions			98,878	98,878		98,878	(71,601)	27,277		20
21	Clerical & General Office Expenses	380,092	66,025	242,523	688,640		688,640	35,678	724,318		21
22	Employee Benefits & Payroll Taxes			1,162,213	1,162,213	24,236	1,186,449		1,186,449		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,668	14,668		14,668	(590)	14,078		24
25	Other Admin. Staff Transportation			2,015	2,015		2,015	1,531	3,546		25
26	Insurance-Prop.Liab.Malpractice			770,268	770,268		770,268	1,772	772,040		26
27	Other (specify):*							48,010	48,010		27
28	TOTAL General Administration	549,137	66,025	3,320,856	3,936,018	23,739	3,959,757	(883,690)	3,076,066		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,831,767	1,334,614	3,827,695	11,994,076	(497)	11,993,579	(846,626)	11,146,953		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

#0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	
	D. Ownership											
30	Depreciation			242,548	242,548		242,548	(2,619)	239,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(0)	(0)			32
33	Real Estate Taxes			478,292	478,292	497	478,789	7,734	486,524			33
34	Rent-Facility & Grounds			1,871,985	1,871,985		1,871,985	352	1,872,337			34
35	Rent-Equipment & Vehicles			15,336	15,336		15,336	4,792	20,128			35
36	Other (specify):*											36
37	TOTAL Ownership			2,608,161	2,608,161	497	2,608,658	10,259	2,618,917			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	14,476	515,318	952,594	1,482,388		1,482,388		1,482,388			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,780	135,780		135,780		135,780			42
43	Other (specify):*	125,080		314,481	439,561		439,561	(439,561)	0			43
44	TOTAL Special Cost Centers	139,556	515,318	1,402,855	2,057,729		2,057,729	(439,561)	1,618,168			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,971,323	1,849,932	7,838,711	16,659,966	0	16,659,966	(1,275,927)	15,384,039			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO, PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(8)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,470)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,411)	30		9
10	Interest and Other Investment Income	(4,187)	32		10
11	Discounts, Allowances, Rebates & Refunds	(810)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	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	(14)	21		18
19	Entertainment	(2,028)	24		19
20	Contributions	(28,150)	20		20
21	Owner or Key-Man Insurance	(17,675)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,500)	21		24
25	Fund Raising, Advertising and Promotional	(34,681)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,491)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,196)	20		28
29	Other-Attach Schedule	(492,884)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (725,626)		\$	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)	(550,301)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (550,301)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,275,927)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

The Renaissance at South Shore

ID# 0042085

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Needs	\$ (3,464)	10	1
2	Patient Clothing	(15,066)	10	2
3	Bank Charges	(21,740)	21	3
4	Food Vendor Rebates	(120)	02	4
5	Maintenance Vendor Rebates	(8)	06	5
6	Settlement	(27)	26	6
7	Income from copies	(984)	21	7
8	Income from transportation	(12)	14	8
9	Jury Duty	(68)	10	9
10	Medical Supplies	(23)	10	10
11	Non-allowable Expenses	(41)	19	11
12	Non-allowable and prior year legal	(23,963)	19	12
13	COPE Dues	(8,727)	20	13
14	Annual Report	(350)	20	14
15	Capitalized R&M	(2,999)	06	15
16	Marketing Travel	(6)	43	16
17	Marketing Wages	(75,777)	43	17
18	Guest Service Coordinator	(49,303)	43	18
19	Additonal R&M	24,267	06	19
20	Non-Allowable Admin. Fees	(314,475)	43	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(492,884)		49

The Renaissance at South Shore

ID# 0042085

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Renaissance at South Shore# 0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10

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													1
2	Food Purchase	(1,059)											(1,059)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,470)		2,822									(3,648)	5
6	Maintenance	21,261		6,877									28,138	6
7	Other (specify):*													7
8	TOTAL General Services	13,732		9,700									23,431	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(18,622)				32,267							13,645	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(12)											(12)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(18,634)				32,267							13,633	16
	C. General Administration													
17	Administrative			(687,058)	5,906	(58,046)	(146,741)						(885,939)	17
18	Directors Fees													18
19	Professional Services	(24,004)		10,953		36	463						(12,552)	19
20	Fees, Subscriptions & Promotions	(73,103)		1,467		36							(71,601)	20
21	Clerical & General Office Expenses	(166,404)		174,393		26,532	1,157						35,678	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,028)		1,255		183							(590)	24
25	Other Admin. Staff Transportation			1,278		253							1,531	25
26	Insurance-Prop.Liab.Malpractice	(27)		1,799									1,772	26
27	Other (specify):*			38,794	239	8,155	822						48,010	27
28	TOTAL General Administration	(265,566)		(457,120)	6,145	(22,851)	(144,299)						(883,690)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(270,467)		(447,420)	6,145	9,416	(144,299)						(846,626)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Renaissance at South Shore# 0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(11,411)		8,635		157							(2,619)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,187)		3,967		220							(0)	32
33	Real Estate Taxes			7,734									7,734	33
34	Rent-Facility & Grounds			352									352	34
35	Rent-Equipment & Vehicles			4,792									4,792	35
36	Other (specify):*													36
37	TOTAL Ownership	(15,598)		25,480		377							10,259	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(439,561)											(439,561)	43
44	TOTAL Special Cost Centers	(439,561)											(439,561)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(725,626)		(421,940)	6,145	9,793	(144,299)						(1,275,927)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,822	\$ 2,822
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	6,877	6,877
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	17,787	17,787
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	10,953	10,953
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,467	1,467
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	174,393	174,393
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,255	1,255
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,278	1,278
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,799	1,799
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	38,794	38,794
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,635	8,635
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,967	3,967
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	7,734	7,734
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	352	352
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	4,792	4,792
30	V						
31	V						
32	V	17 Management Fees	704,845				(704,845)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 704,845			\$ 282,905	\$ * (421,940)

* 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 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	5,906	\$	5,906	15		
16	V								16		
17	V								17		
18	V								18		
19	V								19		
20	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	239		239	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		\$				\$	6,145	\$ *	6,145	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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 32,267	\$ 32,267
16	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	36	36
17	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	36	36
18	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	23,573	23,573
19	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,959	2,959
20	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	183	183
21	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	253	253
22	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,841	3,841
23	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	4,314	4,314
24	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	157	157
25	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	220	220
26	V						
27	V						
28	V	17 ADMINISTRATIVE FEES	58,046	CLINICAL CONSULTING SERVICES, LLC	100.00%		(58,046)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 58,046			\$ 67,839	\$ * 9,793

* 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 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 9,259	\$	9,259	15
16	V	19 PROFESSIONAL FEES				463		463	16
17	V	21 OFFICE				1,157		1,157	17
18	V	27 PAYROLL TAXES				822		822	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17 MANAGEMENT FEES	156,000					(156,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 156,000			\$ 11,701	\$ *	(144,299)	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 Wormans Comp	\$ 87,544	Diamond Insurance	100.00%	\$ 87,544	\$	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		\$ 87,544			\$ 87,544	\$ *	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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number The Renaissance at South Shore # 0042085 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	David Hartman	Relative	Administrative	0%	See Attached	0.88	2.20%		\$	1
2	Robert Hartman	Relative	Administrative	0%	See Attached	1.48	2.96%	Alloc. Salary	5,906	17-03
3	Jack Rajchenbach	Relative	Administrative	0%	See Attached	5.00	7.69%	Alloc. Salary	9,259	17-03
4	David Schechter	Owner	Administrator	1.21%	None	35.00	100.00%	Salary	122,882	17-01
5										5
6										6
7	Were applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only									
8	amounts anticipated to be considered allowable by the Il. Dept of HFS.									
9										9
10										10
11										11
12										12
13								TOTAL	\$ 138,047	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	1,226,110	16	\$ 38,227	\$ 90,520	\$ 2,822	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156	90,520	6,877	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	17,787	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362	90,520	10,953	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864	90,520	1,467	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	174,393	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998	90,520	1,255	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306	90,520	1,278	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362	90,520	1,799	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475	90,520	38,794	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967	90,520	8,635	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729	90,520	3,967	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761	90,520	7,734	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765	90,520	352	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914	90,520	4,792	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,832,004	\$ 2,265,297	\$ 282,905	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	1	5,906	1
2									2
3									3
4									4
5									5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234	1	239	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					\$ 83,234	\$ 80,000	\$ 6,145	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V 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	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,226,110	16	\$ 437,066	\$ 437,066	90,520	32,267	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484		90,520	36	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	1,226,110	16	488		90,520	36	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	90,520	23,573	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077		90,520	2,959	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	1,226,110	16	2,480		90,520	183	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430		90,520	253	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028		90,520	3,841	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440		90,520	4,314	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132		90,520	157	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985		90,520	220	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					\$ 918,910	\$ 756,366		\$ 67,839	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED 54	9	\$ 100,000	\$ 100,000	5	\$ 9,259	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 54	9	5,000		5	463	2
3	21	OFFICE	AVG. HOURS WORKED 54	9	12,497	12,497	5	1,157	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED 54	9	8,881		5	822	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				\$ 126,378	\$ 112,497		\$ 11,701	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Workers Compensation	Direct Allocation		\$	\$		\$ 87,544	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				\$	\$		\$ 87,544	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc from 7257 N. Lincoln</u>	<u>80,865</u>	<u>2004</u>	<u>\$ 11,222</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	80,865		\$ 11,222	3

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1998	78,106		20	3,905	3,905	47,475
10	Various		1999	88,720		20	4,436	4,436	51,587
11	Various		2000	72,602		20	3,630	3,630	38,720
12	Various		2001	45,629		20	2,281	2,281	21,985
13	Various		2002	11,757		20	1,176	1,176	10,423
14	Various		2003	16,299		20	1,630	1,630	12,519
15	Various		2004	62,649		20	6,312	6,312	41,958
16	Various		2005	10,333		20	806	806	5,505
17	Various		2006	69,856		20	8,979	8,979	40,984
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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								67
68		213,642	6,688		8,535	1,847	36,161	68
69			242,548			(242,548)		69
70		\$ 669,593	\$ 249,236		\$ 41,691	\$ (207,545)	\$ 307,316	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 669,593	\$ 249,236		\$ 41,691	\$ (207,545)	\$ 307,316	1
2	New Boiler Pump	2007	2,005		20	167	167	654	2
3	Audio/Visual Equipment In Kitchen Area	2007	2,320		20	331	331	1,215	3
4	Resident Room	2007	7,800		20	780	780	3,120	4
5	Built-In Equipment	2007	3,340		20	334	334	1,336	5
6	Relaminate 11 Doors	2007	2,820		20	282	282	1,105	6
7	West Wing	2007	4,198		20	420	420	1,609	7
8	East Wing	2007	3,730		20	373	373	1,430	8
9	2Nd Floor Tv Room [I]	2007	1,950		20	195	195	748	9
10	2Nd Floor Tv Room [Ii]	2007	4,198		20	420	420	1,609	10
11	2Nd Floor Tv Room [Iii]	2007	3,730		20	373	373	1,430	11
12	2Nd Floor Tv Room [Iv]	2007	1,950		20	195	195	748	12
13	Paint One 4 Beds Room [I]	2007	2,326		20	233	233	872	13
14	Paint One 4 Beds Room [Ii]	2007	3,952		20	395	395	1,482	14
15	Paint One 4 Beds Room [Iii]	2007	2,326		20	233	233	872	15
16	Paint One 4 Beds Room [Iv]	2007	3,952		20	395	395	1,482	16
17	2Nd Floor East In 13 Resident Bathrooms [I]	2007	3,050		20	305	305	1,118	17
18	2Nd Floor East In 13 Resident Bathrooms [Ii]	2007	3,050		20	305	305	1,118	18
19	East Wing - Paint 1 One-Bed Room; 8 Two-Beds Room; 1 Four B	2007	2,735		20	274	274	980	19
20	West Wing - Paint 2 One-Bed Room; 14 Two-Beds Room; 1 Four	2007	4,565		20	457	457	1,636	20
21	West Wing - Paint 2 One-Bed Room; 14 Two-Beds Room; 1 Four	2007	3,050		20	305	305	1,118	21
22	West Wing - Paint 2 One-Bed Room; 14 Two-Beds Room; 1 Four	2007	3,050		20	305	305	1,118	22
23	West Wing - Paint 2 One-Bed Room; 14 Two-Beds Room; 1 Four	2007	2,735		20	274	274	980	23
24	West Wing - Paint 2 One-Bed Room; 14 Two-Beds Room; 1 Four	2007	4,565		20	457	457	1,636	24
25	Built-In Cabinets Windows 3Rd Floor Patio	2007	3,400		20	340	340	1,247	25
26	6 Built-In Cabinet Room Dividers For Patient Rooms [I]	2007	3,600		20	360	360	1,320	26
27	6 Built In Cabinet Room Dividers For Patient Rooms [Ii]	2007	3,400		20	340	340	1,247	27
28	6 Built In Cabinet Room Dividers For Patient Rooms [Iii]	2007	3,600		20	360	360	1,320	28
29	4Th Floor Dinning Room	2007	920		20	92	92	337	29
30	1St Floor Tv Room	2007	1,140		20	114	114	409	30
31	Chair Rails	2007	2,099		20	210	210	735	31
32	Cubicle Curtains	2007	11,529		20	1,153	1,153	4,131	32
33	Cornice Boards	2007	8,302		20	830	830	2,906	33
34	TOTAL (lines 1 thru 33)		\$ 784,978	\$ 249,236		\$ 53,295	\$ (195,941)	\$ 350,383	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 784,978	\$ 249,236		\$ 53,295	\$ (195,941)	\$ 350,383	1
2	<u>Mecho Shades</u>	2007	8,241		20	824	824	2,884	2
3	<u>Elevator Machine Room Air Conditioner</u>	2007	4,200		20	420	420	1,470	3
4	<u>1St Floor Hallway [I]</u>	2007	3,400		20	340	340	1,162	4
5	<u>1St Floor Hallway [Ii]</u>	2007	3,000		20	300	300	1,025	5
6	<u>Elevator Airconditioning</u>	2007	9,700		20	970	970	3,314	6
7	<u>Dinning Room Floor [I]</u>	2007	2,987		20	299	299	1,046	7
8	<u>Dinning Room Floor [Ii]</u>	2007	2,987		20	299	299	1,046	8
9	<u>455 Yds Wall Paper</u>	2007	19,608		20	1,961	1,961	6,699	9
10	<u>Video Equipment Purchase/Installation [I]</u>	2007	1,139		20	163	163	570	10
11	<u>Video Equipment Purchase/Installation [Ii]</u>	2007	818		20	117	117	409	11
12	<u>Video Equipment Purchase/Installation [Iii]</u>	2007	1,139		20	163	163	570	12
13	<u>Video Equipment Purchase/Installation [Iv]</u>	2007	818		20	117	117	409	13
14	<u>3Rd Floor Nurses Station [I]</u>	2007	4,508		20	451	451	1,540	14
15	<u>3Rd Floor Nurses Station [Ii]</u>	2007	4,508		20	451	451	1,540	15
16	<u>30 Yds Border And 56 Yds Wall Paper</u>	2007	1,819		20			1,819	16
17	<u>Hot Water Circulation Pump</u>	2007	2,770		20	277	277	1,039	17
18	<u>Demolish Parking Lot And Replace [I]</u>	2007	2,363		20	236	236	788	18
19	<u>Demolish Parking Lot And Replace [Ii]</u>	2007	2,563		20	256	256	854	19
20	<u>6 Table Tops; 10 Doors Refaced For Nsg Station</u>	2007	4,260		20	426	426	1,385	20
21	<u>Wallpaper Border</u>	2007	2,058		20			2,058	21
22	<u>Wallpaper</u>	2007	394		20			394	22
23	<u>Video Equip Purchase/Install</u>	2007	553		20	79	79	257	23
24	<u>Carpeting</u>	2007	1,244		20	178	178	548	24
25	<u>Cubicle Curtains</u>	2007	5,446		20	545	545	1,906	25
26	<u>6/7/05 Wood Products Co Return</u>	2007	(2,510)		20	(251)	(251)	(774)	26
27	<u>Annealed 1/8" Clear Glass</u>	2008	611		20	61	61	178	27
28	<u>Reface Hallway Doors; Cabinets & Desk Pt Office; Doors</u>	2008	3,480		20	348	348	986	28
29	<u>Heating/Cooling Plant</u>	2008	2,835		20	283	283	756	29
30	<u>Concrete Cutting & Installment Of Ramp</u>	2008	8,000		20	800	800	2,000	30
31	<u>Teledyne Laars Cooper Heat Exchanger</u>	2008	2,869		20	287	287	693	31
32	<u>Replaced Carpet</u>	2008	1,491		20	149	149	360	32
33	<u>Exhaust Ventilator</u>	2008	1,383		20	138	138	346	33
34	TOTAL (lines 1 thru 33)		\$ 893,661	\$ 249,236		\$ 63,981	\$ (185,255)	\$ 389,659	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 893,661	\$ 249,236		\$ 63,981	\$ (185,255)	\$ 389,659	1
2	Installed Furnished Tiles - Dining Room	2008	3,482		20	348	348	812	2
3	Furnish & Install Dome Camera; Power Cable	2008	1,600		20	160	160	427	3
4	Cabinetry For Office And Reception Area; Front Windows	2008	14,300		20	1,430	1,430	3,218	4
5	Remove Old Tub; Install New Tub	2008	3,000		20	300	300	700	5
6	New Duro Last Roofing System	2008	51,750		20	3,450	3,450	8,050	6
7	3Rd Flr Chair Rail, End Cap	2008	2,981		20	298	298	671	7
8	New Wallcovering	2008	16,698		20	1,670	1,670	3,757	8
9	Automatic Door Operating Equipment	2008	7,619		20	762	762	1,651	9
10	Pt Room And 4Th Floor Nursing Station Countertops; Reface Fro	2008	7,850		20	785	785	1,635	10
11	Pt Room Flooring; Build Office Space; Install Vinyl Plank Floorin	2008	8,790		20	879	879	1,831	11
12	Nathan Maple In Basement, 2Nd Floor, And Dining Room; Techn	2009	59,562		20	3,971	3,971	6,949	12
13	Cabinet Mail Box, Tv Stands, Servicing Units, Kitchen Counter A	2009	7,500		20	1,500	1,500	2,625	13
14	Heating And Air Conditioning System - Replacement	2009	15,320		20	1,277	1,277	2,234	14
15	Flooring Materials For 4Th Floor Corridor	2009	11,637		20	776	776	1,228	15
16	Additional Flooring Materials	2009	2,773		20	185	185	293	16
17	Light Fixtures, Light Switches, Circuit Panel	2009	5,525		20	553	553	829	17
18	Resident Room Painting	2009	12,350		20	1,235	1,235	1,955	18
19	2Nd & 4Th Floor- Wall Covering, Cove Base, Handrails, Paint	2009	92,038		20	9,204	9,204	13,806	19
20	Removing Wallpaper And Painting Resident Rooms	2009	18,475		20	1,848	1,848	2,463	20
21	Pleated Shades And Faux Wood Blinds	2009	4,670		20	467	467	623	21
22	Tadiran Ipx500 Telephone System	2009	24,875		20	2,488	2,488	3,731	22
23	Tadiran Ipx500 Telephone System	2009	24,875		20	2,488	2,488	3,524	23
24	2Nd And 4Th Flr- Lights, Signage, Wallcovering, Cove Base, Pain	2009	118,364		20	11,836	11,836	16,768	24
25	Vet Tile And Installation	2009	4,020		20	268	268	335	25
26	Usa Satellite Camera	2009	2,626		20	375	375	438	26
27	Handrails, Bumpers, Corner Guards, Cove Base, Etc	2009	15,860		20	3,172	3,172	3,701	27
28	Custom Office Cabinetry	2009	13,150		20	877	877	950	28
29	Copper Finned Boiler	2009	10,765		20	1,076	1,076	1,166	29
30	Wallcovering For Basement Corridor, Business Office, Mgrs Offic	2009	13,958		20	2,792	2,792	3,024	30
31	Ceramic Flooring For Shower Room	2009	3,910		20	261	261	282	31
32	Chair Rail For 4Th Floor Resident Rooms	2009	6,803		20	1,361	1,361	1,474	32
33	Reface Front Lobby Doors & Window Ledges	2009	4,000		20	200	200	317	33
34	TOTAL (lines 1 thru 33)		\$ 1,484,787	\$ 249,236		\$ 122,270	\$ (126,966)	\$ 481,126	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,484,787	\$ 249,236		\$ 122,270	\$ (126,966)	\$ 481,126	1
2	Prep And Level Flooring - Furnish And Install 2250 Sq. Ft. Vinyl I	2010	17,701		20	1,770	1,770	1,770	2
3	3Rd Floor Hallway Flooring Installation	2010	5,157		20	516	516	516	3
4	Therapy Rm- Remove Flooring And Carpet, Prep And Level Floor	2010	9,752		20	975	975	975	4
5	Rewire Non Functionng Boiler	2010	2,789		20	256	256	256	5
6	Reface/Laminate 38 Patient Room Doors	2010	5,700		20	475	475	475	6
7	1St Flr Hallway Flooring-Remove, Prep And Level, Install Vinyl P	2010	11,745		20	881	881	881	7
8	1St Flr Hallway Installation Natural 3" Vinyl Plank.	2010	11,780		20	884	884	884	8
9	Remove 850 Sq. Ft. Of 16" Decoria Tile. Prep And Level Floor Wi	2010	4,244		20	248	248	248	9
10	3 Rollershades, 4 Upholstered Cornice In Therapy Rm And Install	2010	7,245		20	725	725	725	10
11	2 Ctns Vinyl Cove Base 4" For Basement Area. Lobby; Furnish/In	2010	28,525		20	2,377	2,377	2,377	11
12	4 Light Fixtures - Entry; Various Signage For 3Rd Flr Corridor; I	2010	9,107		20	531	531	531	12
13	50% Deposit - Awnings Around Facility 4 Flrs 200Ft X 3Ft X 2Ft;	2010	8,150		20	340	340	340	13
14	Fabricate/Install 4 Cabinets, 36"W X 30"H X 12"D; 4 Base Cabin	2010	6,282		20	105	105	105	14
15	2 Light Fixtures Olympia; 2 Sconces Replacement For Lobby; 4 P	2010	3,517		20	205	205	205	15
16	Furnish/Install 36 Cordless Plus Premium Blinds In Hr; Med. Rec	2010	11,845		20	296	296	296	16
17	Remove Old Carpet, Install New Carpet, 4" Cove Base, Furnish C	2010	29,019		20	2,902	2,902	2,902	17
18	Remove 1036 Sq Ft. Decoria Tile, Prep And Level Flr, Furnish An	2010	6,797		20	397	397	397	18
19	Balance Due - Cheery Garden Mural - Alzheimer Unit	2010	2,600		20	46	46	46	19
20	3Rd Floor Assisted Bath-Remove Tiles, Furnish/Install New Tiles	2010	3,172		20	119	119	119	20
21	Balance Due - Installation 16 Windows For 1St, 2Nd And 3Rd Flr	2010	4,973		20	145	145	145	21
22	Painting Moulding	2010	2,999		20	150	150	150	22
23	Prime Vestibule Reception & 3Rd Fl. Hall.	2010	4,925		20	246	246	246	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,682,810	\$ 249,236		\$ 136,856	\$ (112,380)	\$ 495,712	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from NuCare 7257 N. Lincoln Ave	2004	95,680	2,453	35	2,734	281	19,478	3
4	Allocated from Clinical Consulting Services	2004	5,316	136	35	152	16	1,082	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare	2003	865	32	20	43	11	308	9
10	Allocated from NuCare	2004	17,556	640	20	879	239	5,897	10
11	Allocated from NuCare	2005	1,041	38	20	52	14	305	11
12	Allocated from NuCare	2006	1,411	51	20	71	20	308	12
13	Allocated from NuCare	2008	1,488	54	20	74	20	168	13
14	Allocated from NuCare	2009	75,390	2,749	20	3,770	1,021	4,714	14
15	Allocated from NuCare	2010	3,681	134	20	93	(41)	93	15
16	Allocated from NuCare 7257 N. Lincoln Ave	2004	1,901		20	95	95	618	16
17	Allocated from NuCare 7257 N. Lincoln Ave	2005	8,722	380	20	536	156	2,990	17
18	Allocated from Clinical Consulting Services	2004	106		20	5	5	34	18
19	Allocated from Clinical Consulting Services	2005	485	21	20	31	10	166	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 213,642	\$ 6,688		\$ 8,535	\$ 1,847	\$ 36,161	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 772,077	\$ 1,733	\$ 91,182	\$ 89,449	10	\$ 507,824	71
72	Current Year Purchases	103,178	347	11,522	11,175	10	11,522	72
73	Fully Depreciated Assets	214,225		315	315	10	214,225	73
74								74
75	TOTALS	\$ 1,089,480	\$ 2,080	\$ 103,018	\$ 100,938		\$ 733,571	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		Allocated from Nucare	1905	\$ 654	\$ 24	\$ 54	\$ 30	5	\$ 54	76
77										77
78										78
79										79
80	TOTALS			\$ 654	\$ 24	\$ 54	\$ 30		\$ 54	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)	\$ 2,784,166	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 251,340	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 239,928	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,411)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,229,337	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: South Shore Partnership

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: <u>1998</u>	<u>248</u>		\$ <u>1,867,305</u>			3
4	Additions						4
5	<u>Parking Rent</u>			<u>4,680</u>			5
6	<u>Alloc from NuCare</u>			<u>352</u>			6
7	TOTAL	<u>248</u>		\$ <u>1,872,337</u>			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: \$ 16,668 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	<u>Allocated from Nucare</u>		\$ _____	\$ <u>3,461</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,461</u>	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 397,584							\$ 397,584	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					183,790							183,790	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					358,968							358,968	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescripts							437,024					437,024	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>				14,476			12,252		78,294					105,022	13
14	TOTAL				\$ 14,476			\$ 952,594		\$ 515,318					\$ 1,482,388	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore# 0042085Report Period Beginning: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits	6,120		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,394,678		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,448		6
7	Other Prepaid Expenses	564,638		7
8	Accounts Receivable (owners or related parties)	15,723,685		8
9	Other(specify): <u>See Attached Schedule</u>	1,117,776		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,965,345	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,096,695		15
16	Equipment, at Historical Cost	1,056,414		16
17	Accumulated Depreciation (book methods)	(1,736,975)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,557		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,417,691	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,383,036	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,412,410	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	276		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	570,989		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,459		31
32	Accrued Real Estate Taxes(Sch.IX-B)	426,406		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	75		35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	14,937,429		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 17,391,044	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,391,044	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,991,992	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 21,383,036	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,358,453	1
2	Restatements (describe):		2
3	Replacement Tax on Deposit	1,054	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,359,507	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	639,228	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(6,743)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 632,485	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,991,992	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore

0042085

Report Period Beginning: 01/01/10

Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,764,117	1
2	Discounts and Allowances for all Levels	(1,153,354)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,610,763	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,528,390	6
7	Oxygen	3,595	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,531,985	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	867,916	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	114,752	19
20	Radiology and X-Ray	19,125	20
21	Other Medical Services	92,231	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,094,024	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49,068	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,068	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	13,354	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,354	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,299,194	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,093,628	31
32	Health Care	5,964,430	32
33	General Administration	3,936,018	33
B. Capital Expense			
34	Ownership	2,608,161	34
C. Ancillary Expense			
35	Special Cost Centers	1,921,949	35
36	Provider Participation Fee	135,780	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,659,966	40
41	Income before Income Taxes (line 30 minus line 40)**	639,228	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 639,228	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 South Shore**

0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	1,846	2,062	\$ 104,617	\$ 50.74	1
2	Assistant Director of Nursing	1,861	2,036	72,559	35.64	2
3	Registered Nurses	38,710	42,585	1,250,288	29.36	3
4	Licensed Practical Nurses	51,022	55,942	1,353,238	24.19	4
5	CNAs & Orderlies	147,811	163,482	1,838,901	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16,050	17,803	198,905	11.17	8
9	Activity Director	3,836	4,294	78,450	18.27	9
10	Activity Assistants	12,477	14,166	153,564	10.84	10
11	Social Service Workers	6,921	7,871	153,599	19.51	11
12	Dietician	2,849	3,154	75,467	23.93	12
13	Food Service Supervisor					13
14	Head Cook	6,486	7,241	94,820	13.09	14
15	Cook Helpers/Assistants	23,902	27,057	263,595	9.74	15
16	Dishwashers					16
17	Maintenance Workers	6,089	6,998	127,293	18.19	17
18	Housekeepers	21,792	24,022	246,462	10.26	18
19	Laundry	11,652	13,104	143,621	10.96	19
20	Administrator	1,827	2,154	145,249	67.43	20
21	Assistant Administrator	487	508	14,630	28.80	21
22	Other Administrative	396	396	9,166	23.15	22
23	Office Manager					23
24	Clerical	13,893	17,392	380,092	21.85	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	2,332	2,719	77,616	28.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,600	6,058	189,191	31.23	33
34	TOTAL (lines 1 - 33)	377,839	421,043	\$ 6,971,323 *	\$ 16.56	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	260	\$ 11,911	01-03	35
36	Medical Director	Monthly	84,342	09-03	36
37	Medical Records Consultant	19	1,066	10-03	37
38	Nurse Consultant	326	6,448	10-03	38
39	Pharmacist Consultant	Monthly	13,047	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,513	11-03	44
45	Social Service Consultant	17	1,004	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	647	\$ 119,331		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Schechter, David	Administrator	1.210%	\$ 122,882	Workers' Compensation Insurance	\$ 87,544	IDPH License Fee	\$	
Ortega, Connie	Administrator	0	22,367	Unemployment Compensation Insurance	98,092	Advertising: Employee Recruitment	5,621	
Kevin J, McInerney	Assit. Administrator	0	14,630	FICA Taxes	506,359	Health Care Worker Background Check		
Brander, Kathleen	Dir of Regulatory Mgmt	0	988	Employee Health Insurance	341,097	(Indicate # of checks performed <u>200</u>)	2,153	
Flaherty, Marilyn	Dir of MC Reimb	0	8,178	Employee Meals	24,236	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	12,096	
				Union Pension	62,317	Dues and Subscriptions	383	
				Dental Insurance	11,455	Licenses and Fees	5,521	
				City Payroll Tax	12,916	Allocated from NuCare	1,467	
				Other Employee Benefits	42,433	Allocated from Clinical Consulting Serv	36	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 1,186,448	\$ 27,277		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
JLR Management-Management Fees			\$ 156,000				Out-of-State Travel	\$
Nucare Service Corporation-Administrative Fee			704,845					
CCS - Administrative Fee			58,046				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 918,891				Seminar Expense	12,640
							Allocated from NuCare	1,255
							Allocated from Clinical Consulting Services	183
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 111,400	TOTAL		\$	TOTAL	\$ 14,078

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at South Shore# 0042085

Report Period Beginning:

01/01/10

Ending:

12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LILCLTC \$20,822.69
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,345 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. \$ 135,780
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,236 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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.