

		FOR BHF USE					

LL1

**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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>0042085</u></p> <p><b>Facility Name:</b> <u>The Renaissance at So Shore</u></p> <p><b>Address:</b> <u>2425 E 71st Street</u> <u>Chicago</u> <u>60649</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 721-5000</u> <b>Fax #</b> <u>(773) 721-6850</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/23/1998</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <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>  <b>Email Address:</b> _____</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>01/01/13</u> to <u>12/31/13</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"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td rowspan="2"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p><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 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____ (Date) _____	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>Kimberley A. Waite, 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> Fax # <u>(847) 236-1155</u>
<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 _____																																		
<b>Officer or Administrator of Provider</b>	(Signed) _____																																		
	(Type or Print Name) _____ (Date) _____																																		
<b>Paid Preparer</b>	(Signed) _____																																		
	(Print Name and Title) <u>Kimberley A. Waite, 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> Fax # <u>(847) 236-1155</u>																																		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			16,046	16,046	8
9	SNF/PED					9
10	ICF	60,268	2,003	2,465	64,736	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,268	2,003	18,511	80,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.24%

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 10/23/1998

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

YES  Date 10/23/1998 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 14,216

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	446,470	93,999	15,892	556,361		556,361	556,361			1
2	Food Purchase		403,095		403,095	(22,922)	380,173	(100)	380,073		2
3	Housekeeping	254,417	53,133	800	308,350		308,350		308,350		3
4	Laundry	136,471	40,459		176,930		176,930		176,930		4
5	Heat and Other Utilities			247,095	247,095		247,095	(5,822)	241,273		5
6	Maintenance	98,173	117,292	245,570	461,035		461,035	(10,246)	450,789		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	935,531	707,978	509,357	2,152,866	(22,922)	2,129,944	(16,168)	2,113,776		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			90,373	90,373		90,373		90,373		9
10	Nursing and Medical Records	5,553,118	947,001	44,993	6,545,112		6,545,112	(16,086)	6,529,026		10
10a	Therapy	94,691			94,691		94,691		94,691		10a
11	Activities	241,479	12,261		253,740		253,740	1,041	254,781		11
12	Social Services	213,520	223	2,649	216,392		216,392		216,392		12
13	CNA Training										13
14	Program Transportation			2,484	2,484		2,484		2,484		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,102,808	959,485	140,499	7,202,792		7,202,792	(15,045)	7,187,747		16
	<b>C. General Administration</b>										
17	Administrative	178,573		923,310	1,101,883		1,101,883	(867,730)	234,153		17
18	Directors Fees										18
19	Professional Services			129,035	129,035		129,035	15,137	144,172		19
20	Dues, Fees, Subscriptions & Promotions			107,965	107,965		107,965	(71,976)	35,989		20
21	Clerical & General Office Expenses	268,960	86,798	758,728	1,114,486		1,114,486	(408,836)	705,650		21
22	Employee Benefits & Payroll Taxes			1,652,503	1,652,503	22,922	1,675,425		1,675,425		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,354	7,354		7,354	341	7,695		24
25	Other Admin. Staff Transportation			824	824		824	2,124	2,948		25
26	Insurance-Prop.Liab.Malpractice			830,248	830,248		830,248	1,852	832,100		26
27	Other (specify):*							55,149	55,149		27
28	<b>TOTAL General Administration</b>	447,533	86,798	4,409,967	4,944,298	22,922	4,967,220	(1,273,940)	3,693,280		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,485,872	1,754,261	5,059,823	14,299,956		14,299,956	(1,305,153)	12,994,803		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 So Shore

#0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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			276,780	276,780	276,780	(12,837)	263,943				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,653	80,653	80,653	(6,016)	74,637				32
33	Real Estate Taxes			584,790	584,790	584,790	6,930	591,720				33
34	Rent-Facility & Grounds			1,831,827	1,831,827	1,831,827	500	1,832,327				34
35	Rent-Equipment & Vehicles			36,196	36,196	36,196	6,514	42,710				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,810,246	2,810,246	2,810,246	(4,908)	2,805,338				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		641,422	1,621,943	2,263,365	2,263,365	(28,581)	2,234,784				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			551,652	551,652	551,652		551,652				42
43	Other (specify):*	226,070			226,070	226,070	(226,070)					43
44	<b>TOTAL Special Cost Centers</b>	226,070	641,422	2,173,595	3,041,087	3,041,087	(254,651)	2,786,436				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,711,942	2,395,683	10,043,664	20,151,289	20,151,289	(1,564,712)	18,586,577				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

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	(8,614)	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	(28,288)	30		9
10	Interest and Other Investment Income	(7,948)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(100)	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	(1,762)	21		18
19	Entertainment	(611)	24		19
20	Contributions	(27,550)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(543,927)	21		24
25	Fund Raising, Advertising and Promotional	(36,000)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,157)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(396,012)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,056,969)</b>		<b>\$</b>	<b>30</b>

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)	(507,743)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (507,743)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (1,564,712)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

The Renaissance at So Shore

	<u>ID#</u>	<u>0042085</u>
Report Period Beginning:	<u>01/01/13</u>	
Ending:	<u>12/31/13</u>	

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Record Copies	\$ (1,130)	21	1
2	Jury Duty Income	(69)	10	2
3	Patient Needs	(14,935)	10	3
4	Patient Clothing	(7,824)	10	4
5	Community Related Wages	(23,545)	43	5
6	Guest Related Wages	(49,327)	43	6
7	Bank Charges	(19,058)	21	7
8	Theft Expense	(2,000)	21	8
9	Sequestration Fee	(93,368)	21	9
10	Annual Reports	(100)	20	10
11	Non-allowable Seminar	(165)	24	11
12	Out of Period and Non-allowable Legal Fees	(23,884)	19	12
13	2012 Accrual Reversal	30,000	19	13
14	Collection Expense	(9,363)	21	14
15	COPE Dues	(10,132)	20	15
16	Additional R&M	8,300	06	16
17	Capitalized R&M	(26,214)	06	17
18	Marketing Salaries	(153,198)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
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	<b>Total</b>	(396,012)	49

The Renaissance at So Shore

ID# 0042085

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	(100)											(100)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,614)		2,792									(5,822)	5
6	Maintenance	(17,914)		7,668									(10,246)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(26,628)</b>		<b>10,460</b>									<b>(16,168)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(22,828)		6,876					(134)				(16,086)	10
10a	Therapy													10a
11	Activities			1,041									1,041	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>(22,828)</b>		<b>7,917</b>					<b>(134)</b>				<b>(15,045)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(880,230)			12,500						(867,730)	17
18	Directors Fees													18
19	Professional Services	6,116		8,396			625						15,137	19
20	Fees, Subscriptions & Promotions	(73,782)		1,806									(71,976)	20
21	Clerical & General Office Expenses	(676,765)		262,517			5,412						(408,836)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(776)		1,117									341	24
25	Other Admin. Staff Transportation			2,124									2,124	25
26	Insurance-Prop.Liab.Malpractice			1,852									1,852	26
27	Other (specify):*			53,607			1,542						55,149	27
28	<b>TOTAL General Administration</b>	<b>(745,207)</b>		<b>(548,812)</b>			<b>20,079</b>						<b>(1,273,940)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(794,663)</b>		<b>(530,435)</b>			<b>20,079</b>		<b>(134)</b>				<b>(1,305,153)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(28,288)		15,451									(12,837)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,948)		1,932									(6,016)	32
33	Real Estate Taxes			6,930									6,930	33
34	Rent-Facility & Grounds			500									500	34
35	Rent-Equipment & Vehicles			6,514									6,514	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(36,236)</b>		<b>31,328</b>									<b>(4,908)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(14,330)	(7,613)	(6,638)			(28,581)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(226,070)											(226,070)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(226,070)</b>						<b>(14,330)</b>	<b>(7,613)</b>	<b>(6,638)</b>			<b>(254,651)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,056,969)</b>		<b>(499,107)</b>			<b>20,079</b>	<b>(14,330)</b>	<b>(7,747)</b>	<b>(6,638)</b>			<b>(1,564,712)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,792	\$ 2,792
16	V	6 MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	947	947
17	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	6,721	6,721
18	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	6,876	6,876
19	V	11 ACTIVITY SALARIES		NUCARE SERVICES CORP.	100.00%	1,041	1,041
20	V	17 ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	43,080	43,080
21	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	8,396	8,396
22	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,806	1,806
23	V	21 CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	235,615	235,615
24	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	26,901	26,901
25	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,117	1,117
26	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	2,124	2,124
27	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,852	1,852
28	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	53,607	53,607
29	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	15,451	15,451
30	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,932	1,932
31	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,930	6,930
32	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	500	500
33	V	35 AUTO LEASE		NUCARE SERVICES CORP.	100.00%	4,012	4,012
34	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,502	2,502
35	V						
36	V	17 BOOKKEEPING FEES	923,310	NUCARE SERVICES CORP.	100.00%		(923,310)
37	V						
38	V						
39	Total		\$ 923,310			\$ 424,203	\$ * (499,107)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workmans Comp	\$ 69,834	DIAMOND INSURANCE		\$ 69,834	\$	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		\$ 69,834			\$ 69,834	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workers Compensation	\$ 156,731	MAPLE LEAF		\$ 156,731	\$	15
16	V	26 Liability Insurance	377,239	MAPLE LEAF		377,239		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		\$ 533,970			\$ 533,970	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR FINANCIAL SERVICES CORP.	100.00%	\$ 12,500	\$	12,500	15
16	V	19 PROFESSIONAL FEES		JLR FINANCIAL SERVICES CORP.	100.00%	625		625	16
17	V	21 OFFICE		JLR FINANCIAL SERVICES CORP.	100.00%	5,412		5,412	17
18	V	27 EMPLOYEE BENEFITS		JLR FINANCIAL SERVICES CORP.	100.00%	1,542		1,542	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		\$			\$ 20,079	\$ *	20,079	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 DME and Medical Supplies	\$ 326,670	Integra Healthcare Equipment	100.00%	\$ 312,340	\$ (14,330)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
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		\$ 326,670			\$ 312,340	\$ * (14,330)

\* 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	10 Ambulance	\$ 765	Lifeline Ambulance	100.00%	\$ 631	\$	(134)	15
16	V	39 Ambulance	43,552	Lifeline Ambulance	100.00%	35,939		(7,613)	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		\$ 44,317			\$ 36,570	\$ *	(7,747)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Respiratory Service	\$ 33,070	Integra Respiratory Service		\$ 26,432	\$ (6,638)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
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		\$ 33,070			\$ 26,432	\$ * (6,638)

\* 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: 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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	4.84%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REI	CHICAGO	JLR FINANCIAL SERVICES CO	LINCOLNWOOD	MANAGEMENT CO.	1
2	JONATHAN BRYAN STERN TRUST 2001	0.89%	CALIFORNIA GARDENS CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	2
3	MARSHALL A. MAUER	6.17%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	3
4	MAURICE I. AARON	4.69%	CLARIDGE IMPERIAL, LTD.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5	ORIOLE TRUST	4.89%	JACKSON CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	5
6	RAJCHENBACH FAMILY TRUST	24.70%	MONROE CORP.	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	6
7	ROBERT HARTMAN FAMILY TRUST	21.02%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP	7
8	SUSAN L. STERN	4.84%	ARIA POST ACUTE CARE	HILLSIDE	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPL	8
9	TODD ANDREW STERN TRUST 2001	0.89%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10	MARK HOLLANDER DISCRETIONARY TRUST	8.23%	RENAISSANCE EAST	MESA, ARIZONA	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	10
11	SHARON HOLLANDER DISCRETIONARY TRUST	8.23%	RENAISSANCE PARK SOUTH, LLC	CHICAGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY	11
12	FEIGE C. KNOBEL DISCRETIONARY TRUST	8.23%	RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13	JONATHAN AARON	1.48%	RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14	EVAN MICHAEL STERN 2005 TRUST	0.89%	RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT-HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore # 0042085 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Jack Rajchenbach	Relative	Administrative	0	See Attached	6	10.00%	Alloc. Salary	\$ 12,500	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 12,500		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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 1,205,960	16	\$ 37,199	\$	90,520	\$ 2,792	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	12,620	12,620	90,520	947	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 1,205,960	16	89,537		90,520	6,721	3
4	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	91,606	91,606	90,520	6,876	4
5	11	ACTIVITY SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	13,872	13,872	90,520	1,041	5
6	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS 1,205,960	16	573,931	573,931	90,520	43,080	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,205,960	16	111,853		90,520	8,396	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 1,205,960	16	24,065		90,520	1,806	8
9	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS 1,205,960	16	3,139,005	3,139,005	90,520	235,615	9
10	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 1,205,960	16	358,395		90,520	26,901	10
11	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 1,205,960	16	14,876		90,520	1,117	11
12	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 1,205,960	16	28,298		90,520	2,124	12
13	26	INSURANCE	AVAIL. CENSUS DAYS 1,205,960	16	24,669		90,520	1,852	13
14	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 1,205,960	16	714,188		90,520	53,607	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,205,960	16	205,852		90,520	15,451	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 1,205,960	16	25,740		90,520	1,932	16
17	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 1,205,960	16	92,330		90,520	6,930	17
18	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 1,205,960	16	6,664		90,520	500	18
19	35	AUTO LEASE	AVAIL. CENSUS DAYS 1,205,960	16	53,447		90,520	4,012	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 1,205,960	16	33,335		90,520	2,502	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,651,481	\$ 3,831,033		\$ 424,203	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Slokie Blvd., Suite 105  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number (847) 599-1002  
 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	22	Workers Compensation	Direct Allocation		\$	\$		\$ 69,834	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				\$	\$		\$ 69,834	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Maple Leaf Insurance  
 Street Address PO Box 69,720 West Bay Rd.  
 City / State / Zip Code Grand Cayman KY1-1102  
 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	22	Workers Compensation			\$	\$		\$ 156,731	1
2	26	Libility Insurance						377,239	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				\$	\$		\$ 533,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 FINANCIAL SERVICES 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	
17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	48	9	\$ 100,000	\$ 100,000	6	\$ 12,500	1
19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	9	5,000		6	625	2
21	OFFICE	AVG. HOURS WORKED	48	9	43,293	43,293	6	5,412	3
27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	48	9	12,338		6	1,542	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				\$ 160,631	\$ 143,293		\$ 20,079	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Integra Healthcare Equipment, LLC  
 Street Address 747 Church Road  
 City / State / Zip Code Elmhurst, IL 60126  
 Phone Number ( 630) 834-3700  
 Fax Number ( 630) 834-1500

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	39	DME and Medical Supplies	Direct Allocation		\$	\$		\$ 312,340	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				\$	\$		\$ 312,340	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Lifeline Ambulance LLC  
 Street Address 2424 S. Wabash Ave  
 City / State / Zip Code Chicago, IL 60616  
 Phone Number (312) 949-9595  
 Fax Number (312) 9499262

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	10	Ambulance		Direct Allocation		\$		\$ 631	1
2	39	Ambulance		Direct Allocation				35,939	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					\$		\$ 36,570	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Integra Respiratory Service  
 Street Address 747 Church Road  
 City / State / Zip Code Elmhurst, IL 60126  
 Phone Number ( 630) 834-3700  
 Fax Number ( 630) 834-1500

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	39	Respiratory Service	Direct Allocation		\$	\$		\$ 26,432	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				\$	\$		\$ 26,432	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11					
		Related**					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							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6	Private Bank		X	Line of Credit				1,708,138			80,653	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$ 1,708,138			\$ 80,653	9					
	<b>B. Non-Facility Related*</b>																
10	Interest Income		X								(7,948)	10					
11	Alloc from Nuicare		X								687	11					
12	Alloc. From 7257 N. Lincoln		X								1,245	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (6,016)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,708,138			\$ 74,637	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_

\* 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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>															
	<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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2012 report.		\$	<b>495,154</b>		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>541,556</b>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>46,402</b>		3														
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>545,318</b>		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>591,720</b>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>337,347</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>406,100</u>	9																
	2010	<u>507,745</u>	10																
	2011	<u>490,252</u>	11																
	2012	<u>534,626</u>	12																
<b>2013 Accrual = \$534,626 x 1.02 = \$545,318</b>																			
<b>Allocated from Nucare \$6,930</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

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Renaissance at So Shore COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0042085  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-101-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>41,616.17</u>	\$ <u>41,616.17</u>
2. <u>21-30-101-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>78,231.75</u>	\$ <u>78,231.75</u>
3. <u>21-30-101-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>212,980.89</u>	\$ <u>212,980.89</u>
4. <u>21-30-101-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>57,986.05</u>	\$ <u>57,986.05</u>
5. <u>21-30-101-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>143,811.10</u>	\$ <u>143,811.10</u>
6. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>88,815.89</u>	\$ <u>6,666.57</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>623,441.85</u></u>	\$ <u><u>541,292.53</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**



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 So Shore

# 0042085 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc from 7257 N. Lincoln</u>			\$ <u>12,010</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>12,010</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	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		1998		78,106		20	3,905	3,905	59,191	9
10	Various		1999		88,720		20	4,436	4,436	64,895	10
11	Various		2000		72,602		20	3,630	3,630	49,610	11
12	Various		2001		45,629		20	2,281	2,281	28,829	12
13	Various		2002		11,757		20			11,757	13
14	Various		2003		16,299		20	521	521	16,299	14
15	Various		2004		62,649		20	5,628	5,628	59,272	15
16	Various		2005		10,333		20	647	647	7,724	16
17	Various		2006		72,736		20	4,351	4,351	58,526	17
18	Various		2007		176,978		20	17,866	17,866	117,437	18
19	Various		2008		131,853		20	11,460	11,460	60,736	19
20	Various		2009		441,303		20	44,931	44,931	198,595	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F &amp; 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H &amp; 12I)</u>		171,342	7,772		6,383	(1,389)	54,394	68
69	<u>Financial Statement Depreciation</u>			276,780			(276,780)		69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,380,306	\$ 284,552		\$ 106,039	\$ (178,513)	\$ 787,265	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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,380,306	\$ 284,552		\$ 106,039	\$ (178,513)	\$ 787,265	1
2	3Rd Floor Hallway Flooring	2010	22,858		20	4,572	4,572	18,286	2
3	Therapy Rm- Remove Flooring And Carpet, Prep And Level Floor	2010	9,752		20	1,950	1,950	7,801	3
4	Rewire Non Functionng Boiler	2010	2,789		20	279	279	1,092	4
5	Reface/Laminate 38 Patient Room Doors	2010	5,700		20	570	570	2,185	5
6	1St Flr Hallway Installation Natural 3" Vinyl Plank.	2010	11,780		20	2,356	2,356	8,835	6
7	Remove 850 Sq. Ft. Of 16" Decoria Tile. Prep And Level Floor Wit	2010	4,244		20	424	424	1,521	7
8	3 Rollershades, 4 Upholstered Cornice In Therapy Rm And Install	2010	7,245		20	725	725	2,898	8
9	2 Ctns Vinyl Cove Base 4" For Basement Area. Lobby; Furnish/In	2010	28,525		20	2,853	2,853	10,935	9
10	4 Light Fixtures - Entry; Various Signage For 3Rd Flr Corridor; E	2010	9,107		20	911	911	3,263	10
11	50% Deposit - Awnings Around Facility 4 Flrs 200Ft X 3Ft X 2Ft;	2010	8,150		20	815	815	2,785	11
12	Fabricate/Install 4 Cabinets, 36"W X 30"H X 12"D; 4 Base Cabine	2010	6,282		20	628	628	1,989	12
13	2 Light Fixtures Olympia; 2 Sconces Replacement For Lobby; 4 Pc	2010	3,517		20	352	352	1,260	13
14	Furnish/Install 36 Cordless Plus Premium Blinds In Hr; Med. Recd	2010	11,845		20	1,185	1,185	3,850	14
15	Remove Old Carpet, Install New Carpet, 4" Cove Base, Furnish Cl	2010	29,019		20	2,902	2,902	11,607	15
16	Remove 1036 Sq Ft. Decoria Tile, Prep And Level Flr, Furnish And	2010	6,797		20	680	680	2,436	16
17	Balance Due - Cherry Garden Mural - Alzheimer Unit	2010	2,600		20	130	130	444	17
18	3Rd Floor Assisted Living Barth-Remove Tiles, Furnish/Install Nev	2010	3,172		20	159	159	595	18
19	Balance Due - Installation Of 16 Windows For 1St, 2Nd, 3Rd Floor	2010	4,973		20	249	249	891	19
20	Painting Moulding	2010	2,999		20	150	150	537	20
21	Prime Vestibule Reception & 3Rd Floor Hall	2010	4,925		20	246	246	923	21
22	300 Ft 5 1/2 Ft Hand Rail Honduras Mahogany, 58 Pcs End Cap, 2	2011	7,591		20	380	380	1,139	22
23	Electrical Work For Crd Access Expansion	2011	5,700		20	570	570	1,710	23
24	Painting Of 32 Resident Rooms Walls, Bathrooms, Therapy Rm, S	2011	18,085		20	1,808	1,808	5,124	24
25	Removal Of Nurses Station - 50% Deposit	2011	7,710		20	771	771	2,185	25
26	Fabricate And Install Cabinets In 4 Shower Rooms 50% Deposit	2011	5,852		20	585	585	1,609	26
27	50% Balance, Awnings Around Facility, 1 Patio Awning, 1 Back D	2011	8,150		20	815	815	2,241	27
28	Furnish And Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	5,386		20	539	539	1,481	28
29	Labor To Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	4,486		20	449	449	1,234	29
30	Replace Corridor Lay In Lighting W/ Corelite T5 On 2Nd, 3Rd An	2011	14,575		20	1,458	1,458	3,887	30
31	Expansion Remodeling Of 2Nd, 3Rd And 4Th Flr Dining Rooms, 9	2011	48,300		20	4,830	4,830	12,880	31
32	Furnish And Install 6 Oak Doors, 2 Drawers And Drwr Fronts In	2011	6,884		20	344	344	918	32
33	Balance Due - Expansion Remodeling Of 2Nd, 3Rd And 4Th Flr D	2011	11,491		20	1,149	1,149	2,969	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,710,795	\$ 284,552		\$ 141,870	\$ (142,682)	\$ 908,775	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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	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>		\$ 1,710,795	\$ 284,552		\$ 141,870	\$ (142,682)	\$ 908,775	1
2	Fabricate And Install One New Flex Sign Face To Replace Existing	2011	13,625		20	908	908	2,347	2
3	Replace 20 Lights, 1St Flr Corridor, 4Th Flr, 29 Wall Sconce Light	2011	10,265		20	1,027	1,027	2,566	3
4	Installation Of Cabinetry And Mouldings - 50% Deposit	2011	8,294		20	829	829	2,281	4
5	3Rd Flr Bathroom Remodeling. Remove Tiles From Wall, Replace	2011	6,050		20	605	605	1,260	5
6	Shower Rooms Project- Dalfiles, Waterproof Membranes, Ceramic	2011	17,407		20	1,741	1,741	3,917	6
7	Service To Vac Out Set Of Triple Drains And A Catch Basin And T	2011	2,725		20	273	273	772	7
8	Uninstall Various Electrical Wiring Piping Junction Boxes And To	2011	3,125		20	313	313	833	8
9	Bathroom Flooring - Ceramic	2012	6,700		20	447	447	893	9
10	Polar Rails In Rooms	2012	2,697		20	135	135	247	10
11	First Floor Bathroom - Ceramic Flooring	2012	7,750		20	517	517	947	11
12	Second Floor Bathroom - Ceramic Flooring	2012	5,500		20	367	367	611	12
13	Replace Boiler Pump, Switch, Gauge	2012	3,320		20	277	277	507	13
14	Bathroom Drywall	2012	2,600		20	260	260	390	14
15	Guard System - Security	2012	2,517		20	503	503	629	15
16	Belts, Heater Hose, Governor Controller, And Actuator	2012	5,409		20	541	541	676	16
17	Elevator Repairs	2012	2,800		20	280	280	350	17
18	21.5" Wide All-In-One Windows; Led Black Light Panel With Sen	2013	25,305		20	4,218	4,218	4,218	18
19	Security Systems - Replaced One Dvr, Cameras, Cctv On Detached	2013	4,878		20	650	650	650	19
20	Awning	2013	6,380		20	372	372	372	20
21	Entrance & Ramp Of Parking Garage	2013	32,575		20	1,267	1,267	1,267	21
22	Wiring For Wi-Fi	2013	7,388		20	975	975	975	22
23	8 Cctvs	2013	4,220		20	422	422	422	23
24	Divider Wall, Cabinet-Room 339, Window Sills-All Resident Room	2013	16,680		20	834	834	834	24
25	Install 2 Cctv Outside Facing Parking Lot....	2013	3,310		20	83	83	83	25
26	Sprinkler System	2013	9,422		20	236	236	236	26
27	Hvac Motors & Blowers	2013	4,813		20	882	882	882	27
28	1St-4Th Floors -Flooring, Light Fixtures, Paint, Cabinetry, Wallco	2013	616,651		20	8,264	8,264	8,264	28
29	Elevator Repairs And 16 Led Recesses Cans	2013	5,480		20	25	25	25	29
30	Replace Bad Lighting Ballast Parking Lot Top And One Mounted	2013	6,660		20	333	333	333	30
31	Boiler Repairs - 4 Ignitors And 2 Boards	2013	6,957		20	348	348	348	31
32	Window Replacement For Room 208 And One Window For Attic S	2013	2,716		20	136	136	136	32
33	Replaced Roof Outside Oxvgen Room	2013	3,920		20	196	196	196	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,568,933	\$ 284,552		\$ 170,131	\$ (114,421)	\$ 947,243	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 So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,568,933	\$ 284,552		\$ 170,131	\$ (114,421)	\$ 947,243	1
2	Labor And Material To Service And Replace □ Siemens Elevator L	2013	2,718		20	136	136	136	2
3	A/C Repair	2013	3,243		20	162	162	162	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,574,895	\$ 284,552		\$ 170,429	\$ (114,123)	\$ 947,541	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 2,574,895	\$ 284,552		\$ 170,429	\$ (114,123)	\$ 947,541	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,574,895	\$ 284,552		\$ 170,429	\$ (114,123)	\$ 947,541	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								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

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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		\$	\$		\$	\$	\$	34

**Building Company Information Continued**

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from NuCare 7257 N. Lincoln Ave	2004	108,087	2,771	20	3,088	317	31,268	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated from NuCare Services	2003	879	85	20	44	(41)	445	9
10	Allocated from NuCare Services	2004	17,850	1,717	20	894	(823)	8,677	10
11	Allocated from NuCare Services	2005	1,058	102	20	53	(49)	468	11
12	Allocated from NuCare Services	2006	1,435	138	20	72	(66)	528	12
13	Allocated from NuCare Services	2008	1,512	146	20	76	(70)	398	13
14	Allocated from NuCare Services	2009	24,351	2,343	20	1,218	(1,125)	5,613	14
15	Allocated from NuCare Services	2010	3,742	360	20	187	(173)	656	15
16	Allocated from NuCare Services	2011	202	19	20	10	(9)	29	16
17	Allocated from NuCare Services	2012	225	22	20	11	(11)	20	17
18									18
19	Allocated from NuCare 7257 N. Lincoln Ave	2005	9,853	69	20	623	554	5,272	19
20	Allocated from NuCare 7257 N. Lincoln Ave	2004	2,148		20	107	107	1,020	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

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information Continued</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 171,342	\$ 7,772		\$ 6,383	\$ (1,389)	\$ 54,394	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 758,845	\$ 7,136	\$ 86,781	\$ 79,645	10	\$ 565,675	71
72	Current Year Purchases	56,917	479	6,595	6,116	10	6,595	72
73	Fully Depreciated Assets	484,062		5	5	10	484,062	73
74								74
75	TOTALS	\$ 1,299,823	\$ 7,615	\$ 93,381	\$ 85,766		\$ 1,056,332	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from NuCare	2013	\$ 665	\$ 64	\$ 133	\$ 69	5	\$ 454	76
77										77
78										78
79										79
80	TOTALS			\$ 665	\$ 64	\$ 133	\$ 69		\$ 454	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)	\$ 3,887,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,231	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,943	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,288)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,004,327	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: South Shore 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>1,829,660</u>			3
4	Additions							4
5	Storage				<u>2,167</u>			5
6	Allocated from NuCare				<u>500</u>			6
7	TOTAL		<u>248</u>		\$ <u>1,832,326</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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: \$ 38,698 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>4,012</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,012</u>	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore # 0042085 Report Period Beginning: 01/01/13 Ending: 12/31/13  
 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?</p> <p style="text-align: right;"> <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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	\$		\$	698,619	\$		\$	698,619	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				162,165				162,165	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				716,130				716,130	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					411,869			411,869	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>						45,029	229,553			274,582	13
14	TOTAL			\$		\$	1,621,943	\$	641,422	\$	2,263,365	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 So Shore# 0042085Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	\$ 10,459	\$	1
2	Cash-Patient Deposits	26,688		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,827,287		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,852		6
7	Other Prepaid Expenses	7,423		7
8	Accounts Receivable (owners or related parties)	2,103,415		8
9	Other(specify): <u>See Attached Schedule</u>	1,339,255		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,323,379	\$	10
	<b>B. Long-Term Assets</b>			
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	2,617,399		15
16	Equipment, at Historical Cost	1,270,317		16
17	Accumulated Depreciation (book methods)	(2,539,543)		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>	27,930		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,376,103	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,699,482	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,850,994	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,844		28
29	Short-Term Notes Payable	1,708,138		29
30	Accrued Salaries Payable	634,102		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,650		31
32	Accrued Real Estate Taxes(Sch.IX-B)	545,318		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	25,238		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,865,284	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,865,284	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,834,198	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,699,482	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,836,996</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustment - Bad Debts</b>	<b>(149,998)</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>2,686,998</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,180,800)</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>328,000</b>	<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>(852,800)</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>1,834,198</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,497,330	1
2	Discounts and Allowances for all Levels	(1,677,466)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 12,819,864</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,707,493	6
7	Oxygen	13,097	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 4,720,590</b>	<b>8</b>
<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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,082,883	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	114,433	19
20	Radiology and X-Ray	40,918	20
21	Other Medical Services	179,609	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,417,843</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,045	24
25	Interest and Other Investment Income***	7,948	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 10,993</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,199	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,199</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 18,970,489</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,152,866	31
32	Health Care	7,202,792	32
33	General Administration	4,944,298	33
<b>B. Capital Expense</b>			
34	Ownership	2,810,246	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,489,435	35
36	Provider Participation Fee	551,652	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 20,151,289</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,180,800)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,180,800)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 9,188,524	44
45	Private Pay - Net Inpatient Revenue	267,743	45
46	Medicare - Net Inpatient Revenue	3,056,671	46
47	Other-(specify) <u>CCHHS</u>	66,965	47
48	Other-(specify) <u>Managed Care, Hospice</u>	239,961	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 12,819,864</b>	<b>49</b>

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	3,520	3,731	\$ 115,132	\$ 30.86	1
2	Assistant Director of Nursing	1,758	1,836	66,227	36.07	2
3	Registered Nurses	48,918	52,852	1,518,745	28.74	3
4	Licensed Practical Nurses	64,228	68,862	1,817,246	26.39	4
5	CNAs & Orderlies	161,975	178,083	1,916,238	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,095	7,869	94,691	12.03	8
9	Activity Director	3,046	3,281	86,527	26.37	9
10	Activity Assistants	11,969	13,566	154,952	11.42	10
11	Social Service Workers	7,755	8,349	213,520	25.57	11
12	Dietician					12
13	Food Service Supervisor	4,411	4,824	98,445	20.41	13
14	Head Cook	6,135	6,531	77,535	11.87	14
15	Cook Helpers/Assistants	23,426	25,809	270,490	10.48	15
16	Dishwashers					16
17	Maintenance Workers	4,387	4,602	98,173	21.33	17
18	Housekeepers	19,832	21,996	254,417	11.57	18
19	Laundry	10,363	12,327	136,471	11.07	19
20	Administrator	1,194	1,428	82,575	57.83	20
21	Assistant Administrator	1,802	2,132	74,185	34.80	21
22	Other Administrative	231	231	21,813	94.43	22
23	Office Manager	1,573	1,683	39,239	23.31	23
24	Clerical	18,281	20,014	229,721	11.48	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	852	913	27,003	29.58	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	10,448	11,111	318,597	28.67	33
34	TOTAL (lines 1 - 33)	413,199	452,030	\$ 7,711,942 *	\$ 17.06	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	338	\$ 15,892	01-03	35
36	Medical Director	Monthly	90,373	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	433	21,537	10-03	38
39	Pharmacist Consultant	Monthly	17,906	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	2,649	12-03	45
46	Other(specify)				46
47	Medical Consultant	Monthly	5,550	10-03	47
48					48
49	TOTAL (lines 35 - 48)	815	\$ 153,907		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-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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Renaissance at So Shore

# 0042085

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 \$26,479
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 738 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. \$ 551,652  
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. \$ 22,922 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
  - d. Have vehicle usage logs been maintained? N/A
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
  - g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.