

		FOR BHF USE				

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

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH License ID Number:</b> <u>0042093</u>	<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>										
<b>Facility Name:</b> <u>Renaissance At 87Th St.</u>											
<b>Address:</b> <u>2940 West 87Th Street</u> <u>Chicago</u> <u>60652</u>	<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</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="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td></tr><tr><td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pffingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(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 Pffingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
Officer or Administrator of Provider			(Signed) _____								
			(Type or Print Name) _____ (Date) _____								
		(Title) _____									
Paid Preparer		(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 Pffingsten Road, Suite 300 Deerfield, IL 60015</u>									
		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>									
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630									
<b>County:</b> <u>Cook</u>											
<b>Telephone Number:</b> <u>(773) 434-8787</u> Fax # <u>(773) 434-8717</u>											
<b>HFS ID Number:</b> _____											
<b>Date of Initial License for Current Owners:</b> <u>07/19/99</u>											
<b>Type of Ownership:</b>											
<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>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> _____											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>210</u>	Skilled (SNF)	<u>210</u>	<u>76,860</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>210</u>	TOTALS	<u>210</u>	<u>76,860</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>16,087</u>	<u>16,087</u>	8
9	SNF/PED					9
10	ICF	<u>42,859</u>	<u>3,859</u>	<u>6,371</u>	<u>53,089</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,859</u>	<u>3,859</u>	<u>22,458</u>	<u>69,176</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.00%

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 07/01/1999

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 210 and days of care provided 11,693

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Renaissance At 87Th St. # 0042093 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	347,080	57,776	15,616	420,472		420,472		420,472		1
2	Food Purchase		328,364		328,364	(28,987)	299,377	(183)	299,194		2
3	Housekeeping		7,286	353,290	360,576		360,576		360,576		3
4	Laundry		37,371	157,066	194,437		194,437		194,437		4
5	Heat and Other Utilities			178,686	178,686		178,686	(5,041)	173,645		5
6	Maintenance	102,390	70,500	151,172	324,062		324,062	25,392	349,454		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	449,470	501,297	855,830	1,806,597	(28,987)	1,777,610	20,168	1,797,778		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			29,500	29,500		29,500		29,500		9
10	Nursing and Medical Records	4,476,746	500,228	104,910	5,081,884		5,081,884	(3,780)	5,078,104		10
10a	Therapy	100,651	21,405		122,056		122,056		122,056		10a
11	Activities	168,263	35,242		203,505		203,505	466	203,971		11
12	Social Services	250,582			250,582		250,582		250,582		12
13	CNA Training										13
14	Program Transportation			2,853	2,853		2,853		2,853		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,996,242	556,875	137,263	5,690,380		5,690,380	(3,314)	5,687,066		16
	<b>C. General Administration</b>										
17	Administrative	125,510		813,929	939,439		939,439	(774,043)	165,396		17
18	Directors Fees										18
19	Professional Services			160,325	160,325	(104)	160,221	(52,808)	107,413		19
20	Dues, Fees, Subscriptions & Promotions			128,999	128,999		128,999	(92,650)	36,349		20
21	Clerical & General Office Expenses	309,272	73,937	505,898	889,107		889,107	(236,938)	652,169		21
22	Employee Benefits & Payroll Taxes			1,414,669	1,414,669	28,987	1,443,656		1,443,656		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,047	18,047		18,047	(6,530)	11,517		24
25	Other Admin. Staff Transportation			5,266	5,266		5,266	1,466	6,732		25
26	Insurance-Prop.Liab.Malpractice			1,218,051	1,218,051		1,218,051	9,874	1,227,925		26
27	Other (specify):*							39,867	39,867		27
28	<b>TOTAL General Administration</b>	434,782	73,937	4,265,184	4,773,903	28,883	4,802,786	(1,111,762)	3,691,024		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,880,494	1,132,109	5,258,277	12,270,880	(104)	12,270,776	(1,094,908)	11,175,868		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Renaissance At 87Th St.

#0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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			158,957	158,957		158,957	406,303	565,260			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest							519,590	519,590			32
33	Real Estate Taxes					104	104	408,063	408,167			33
34	Rent-Facility & Grounds			1,373,831	1,373,831		1,373,831	(1,369,988)	3,843			34
35	Rent-Equipment & Vehicles			23,737	23,737		23,737	5,015	28,752			35
36	Other (specify):*							45,523	45,523			36
37	<b>TOTAL Ownership</b>			1,556,525	1,556,525	104	1,556,629	14,506	1,571,135			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		743,375	1,280,031	2,023,406		2,023,406	(18,419)	2,004,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			377,890	377,890		377,890		377,890			42
43	Other (specify):*	92,002		169,077	261,079		261,079	(261,079)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	92,002	743,375	1,826,998	2,662,375		2,662,375	(279,498)	2,382,877			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	5,972,496	1,875,484	8,641,800	16,489,780		16,489,780	(1,359,900)	15,129,880			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	(7,370)	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	49,208	30		9
10	Interest and Other Investment Income	(4,471)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	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	(15,642)	21		18
19	Entertainment	(6,900)	24		19
20	Contributions	(33,935)	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	(372,363)	21		24
25	Fund Raising, Advertising and Promotional	(50,016)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(374,147)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (815,819)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(544,081)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (544,081)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,359,900)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Renaissance At 87Th St.

	<b>ID#</b>	<b>0042093</b>
<b>Report Period Beginning:</b>		<b>01/01/12</b>
<b>Ending:</b>		<b>12/31/12</b>

<b>NON-ALLOWABLE EXPENSES</b>		<b>Amount</b>	<b>Sch. V Line Reference</b>	
1	COPE Dues	\$ (8,915)	20	1
2	Jury Duty Income	(69)	10	2
3	Records Copies	(447)	10	3
4	Bank Charges	(14,783)	21	4
5	Patient Needs	(18,788)	10	5
6	Patient Clothing	(3,372)	10	6
7	Guest Relations Salary	(53,039)	43	7
8	Non-Allowable Legal	(56,518)	19	8
9	Building Co. - Fees	(100)	20	9
10	Building Co. - Accounting Fees	(9,500)	19	10
11	Building Co. - Trust Fees	(1,655)	21	11
12	Building Co. - Amortization	(2,810)	31	12
13	Annual Reports	(279)	20	13
14	Quest Management Fee	(169,077)	43	14
15	Non-Reimbursable Salary	(38,963)	43	15
16	Additional R&M	19,343	06	16
17	Collection Expense	(15,175)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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>	(374,147)		49

Renaissance At 87Th St.

Report Period Beginning: ID# 0042093  
 Ending: 01/01/12  
 12/31/12

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	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	(183)											(183)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,370)		2,329									(5,041)	5
6	Maintenance	19,343		5,991	58								25,392	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>11,790</b>		<b>8,320</b>	<b>58</b>								<b>20,168</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(22,676)		7,344	11,551								(3,780)	10
10a	Therapy													10a
11	Activities				466								466	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>(22,676)</b>		<b>7,344</b>	<b>12,018</b>								<b>(3,314)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(722,318)	(61,929)	10,204							(774,043)	17
18	Directors Fees													18
19	Professional Services	(66,018)	9,500	3,200		510							(52,808)	19
20	Fees, Subscriptions & Promotions	(93,245)	100	415	80								(92,650)	20
21	Clerical & General Office Expenses	(419,618)	1,655	155,525	21,084	4,417							(236,938)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(6,900)		108	261								(6,530)	24
25	Other Admin. Staff Transportation			1,126	340								1,466	25
26	Insurance-Prop.Liab.Malpractice		9,664	120	91								9,874	26
27	Other (specify):*			37,253	1,386	1,228							39,867	27
28	<b>TOTAL General Administration</b>	<b>(585,781)</b>	<b>20,919</b>	<b>(524,571)</b>	<b>(38,688)</b>	<b>16,359</b>							<b>(1,111,762)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(596,666)</b>	<b>20,919</b>	<b>(508,907)</b>	<b>(26,613)</b>	<b>16,359</b>							<b>(1,094,908)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12 Ending:

12/31/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	49,208	348,840	8,137	118								406,303	30
31	Amortization of Pre-Op. & Org.	(2,810)	2,810										0	31
32	Interest	(4,471)	522,416	1,559	87								519,590	32
33	Real Estate Taxes		401,385	6,678									408,063	33
34	Rent-Facility & Grounds		(1,370,397)	409									(1,369,988)	34
35	Rent-Equipment & Vehicles			4,687	328								5,015	35
36	Other (specify):*		45,523										45,523	36
37	<b>TOTAL Ownership</b>	<b>41,927</b>	<b>(49,423)</b>	<b>21,470</b>	<b>533</b>								<b>14,506</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(18,419)					(18,419)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(261,079)											(261,079)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(261,079)</b>						<b>(18,419)</b>					<b>(279,498)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(815,819)</b>	<b>(28,504)</b>	<b>(487,437)</b>	<b>(26,080)</b>	<b>16,359</b>		<b>(18,419)</b>					<b>(1,359,900)</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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,370,397	Renaissance at Beverly LP	100.00%	\$	(1,370,397)	1
2	V	32 Interest	208	Renaissance at Beverly LP	100.00%	522,624	522,416	2
3	V	36 MIP Expense		Renaissance at Beverly LP	100.00%	45,523	45,523	3
4	V	26 Insurance Expense		Renaissance at Beverly LP	100.00%	9,664	9,664	4
5	V	20 Fees		Renaissance at Beverly LP	100.00%	100	100	5
6	V	19 Accounting Fees		Renaissance at Beverly LP	100.00%	9,500	9,500	6
7	V	21 Trust Fees		Renaissance at Beverly LP	100.00%	1,655	1,655	7
8	V	33 Real Estate Taxes		Renaissance at Beverly LP	100.00%	401,385	401,385	8
9	V	30 Depreciation		Renaissance at Beverly LP	100.00%	348,840	348,840	9
10	V	31 Amortization		Renaissance at Beverly LP	100.00%	2,810	2,810	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,370,605			\$ 1,342,101	\$ * (28,504)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,329	\$ 2,329
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	5,991	5,991
17	V	10 CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	7,344	7,344
18	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	29,682	29,682
19	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	3,200	3,200
20	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	415	415
21	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	155,525	155,525
22	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	108	108
23	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,126	1,126
24	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	120	120
25	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	37,253	37,253
26	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,137	8,137
27	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,559	1,559
28	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,678	6,678
29	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	409	409
30	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	4,687	4,687
31	V						
32	V	17 BOOKKEEPING FEES	752,000	NUCARE SERVICES CORP.	100.00%		(752,000)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 752,000			\$ 264,563	\$ * (487,437)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS / MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 58	\$	58	15
16	V	10 CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	11,551		11,551	16
17	V	11 ACTIVITY CONSULTANT		CLINICAL CONSULTING SERVICES, LLC	100.00%	466		466	17
18	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%				18
19	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	80		80	19
20	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	20,044		20,044	20
21	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,040		1,040	21
22	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	261		261	22
23	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	340		340	23
24	V	26 AUTO INSURANCE		CLINICAL CONSULTING SERVICES, LLC	100.00%	91		91	24
25	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,391		1,391	25
26	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	(6)		(6)	26
27	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	118		118	27
28	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	87		87	28
29	V	34 RENT		CLINICAL CONSULTING SERVICES, LLC	100.00%				29
30	V	35 AUTO LEASE		CLINICAL CONSULTING SERVICES, LLC	100.00%	328		328	30
31	V								31
32	V	17 ADMINISTRATIVE FEES	61,929	CLINICAL CONSULTING SERVICES, LLC	100.00%			(61,929)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 61,929			\$ 35,849	\$ *	(26,080)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR FINANCIAL SERVICES CORP.	100.00%	\$ 10,204	\$	10,204	15
16	V	19 PROFESSIONAL FEES			100.00%	510		510	16
17	V	21 OFFICE			100.00%	4,417		4,417	17
18	V	27 EMPLOYEE BENEFITS			100.00%	1,228		1,228	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17 MANAGEMENT FEES			100.00%				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		\$			\$ 16,359	\$ *	16,359	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workers Compensation	\$ 355,237	DIAMOND INSURANCE		\$ 355,237	\$	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		\$ 355,237			\$ 355,237	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39 DME and Medical Supplies	100,269	Integra Healthcare Equipment	100.00%	81,850	\$	(18,419)	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		\$ 100,269			\$ 81,850	\$ *	(18,419)	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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



**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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.

**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.

**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.

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	4.900%	CALIFORNIA GARDENS CORP.	CHICAGO	RENAISSANCE AT BEVERLY LI		BUILDING CO.	1
2	MARSHALL A. MAUER	6.250%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	2
3	MAURICE I. AARON	4.250%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	ORA AARON	2.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	KFT SERVICES LLC	LINCOLNWOOD	MANAGEMENT CO.	4
5	ORIOLE TRUST	4.950%	JACKSON CORP.	CHICAGO	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	5
6	RAJCHENBACH FAMILY TRUST	25.000%	MONROE CORP.	CHICAGO	JLR FINANCIAL SERVICES CO	LINCOLNWOOD	MANAGEMENT CO.	6
7	ROBERT HARTMAN FAMILY TRUST	20.050%	RENAISSANCE EAST	MESA, ARIZONA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	7
8	SUSAN L. STERN	4.900%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	8
9	MARK HOLLANDER DISCRETIONARY TRUST	8.333%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	9
10	SHARON HOLLANDER DISCRETIONARY TRUST	8.333%	RENAISSANCE WEST	MESA, ARIZONA	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP INS.	10
11	FEIGE C. KNOBEL DISCRETIONARY TRUST	8.333%	RENAISSANCE PARK SOUTH LLC	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPL	11
12	TODD ANDREW STERN 2001 TRUST	0.900%	ARIA POST ACUTE CARE	HILLSIDE	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	12
13	EVAN MICHAEL STERN 2005 TRUST	0.900%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14	JONATHAN BRYAN STERN 2001 TRUST	0.900%	THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO				14
15			CLAREMONT HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 Renaissance At 87Th St. # 0042093 Report Period Beginning: 01/01/12 Ending: 12/31/12

## 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	0.00%	See Attached	5.00	8.33%	Alloc. Sal.	\$ 10,204	17-7	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	\$ 10,204		13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	1,228,556	15	\$ 37,226	\$ 76,860	\$ 2,329	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,228,556	15	95,768	76,860	5,991	2
3	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,228,556	15	117,394	117,394	7,344	3
4	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,228,556	15	474,443	462,325	29,682	4
5	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,228,556	15	51,153	76,860	3,200	5
6	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,228,556	15	6,629	76,860	415	6
7	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,228,556	15	2,485,957	1,190,733	155,525	7
8	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,228,556	15	1,734	76,860	108	8
9	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,228,556	15	18,004	76,860	1,126	9
10	26	INSURANCE	AVAIL. CENSUS DAYS	1,228,556	15	1,913	76,860	120	10
11	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,228,556	15	595,462	76,860	37,253	11
12	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,228,556	15	130,061	76,860	8,137	12
13	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,228,556	15	24,917	76,860	1,559	13
14	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,228,556	15	106,750	76,860	6,678	14
15	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,228,556	15	6,532	76,860	409	15
16	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,228,556	15	74,917	76,860	4,687	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,228,859	\$ 1,770,453		\$ 264,563	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	6	REPAIRS / MINOR EQUIPMEN	BED DAYS AVAILABLE	1,228,556	15	\$ 920	\$ 76,860	\$ 58	1
2	10	CLINICAL SALARIES	BED DAYS AVAILABLE	1,228,556	15	184,643	184,643	11,551	2
3	11	ACTIVITY CONSULTANT	BED DAYS AVAILABLE	1,228,556	15	7,452	7,452	466	3
4	19	PROFESSIONAL FEES	BED DAYS AVAILABLE	1,228,556	15		76,860		4
5	20	DUES, LICENSE & INSPECTIO	BED DAYS AVAILABLE	1,228,556	15	1,272	76,860	80	5
6	21	OFFICE WAGES	BED DAYS AVAILABLE	1,228,556	15	320,385	320,385	20,044	6
7	21	OFFICE EXPENSE	BED DAYS AVAILABLE	1,228,556	15	16,624	76,860	1,040	7
8	24	CONTINUING EDUCATION / SI	BED DAYS AVAILABLE	1,228,556	15	4,175	76,860	261	8
9	25	AUTO EXPENSE	BED DAYS AVAILABLE	1,228,556	15	5,436	76,860	340	9
10	26	AUTO INSURANCE	BED DAYS AVAILABLE	1,228,556	15	1,447	76,860	91	10
11	27	PAYROLL TAXES	BED DAYS AVAILABLE	1,228,556	15	22,241	76,860	1,391	11
12	27	OTHER EMPLOYEE BENEFITS	BED DAYS AVAILABLE	1,228,556	15	(91)	76,860	(6)	12
13	30	DEPRECIATION	BED DAYS AVAILABLE	1,228,556	15	1,892	76,860	118	13
14	32	INTEREST	BED DAYS AVAILABLE	1,228,556	15	1,384	76,860	87	14
15	34	RENT	BED DAYS AVAILABLE	1,228,556	15		76,860		15
16	35	AUTO LEASE	BED DAYS AVAILABLE	1,228,556	15	5,242	76,860	328	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 573,023	\$ 512,480	\$ 76,860	\$ 35,849	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED 49	10	\$ 100,000	\$ 100,000	5	\$ 10,204	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 49	10	5,000		5	510	2
3	21	OFFICE	AVG. HOURS WORKED 49	10	43,284	43,284	5	4,417	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 49	10	12,031		5	1,228	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				\$ 160,315	\$ 143,284		\$ 16,359	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance  
 Street Address 40 Skokie Blvd, Suite 105  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number ( 847) 559-1002  
 Fax Number ( 847) 562-0070

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation		\$	\$		\$ 355,237	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				\$	\$		\$ 355,237	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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					81,850	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				\$	\$		\$ 81,850	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number

Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Mortgage		X	Building			\$	\$ 9,063,831		\$ 522,624	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
<b>Working Capital</b>																				
6	Allocated from Nucare		X							1,559	6									
7	Allocated from Clinical Consult		X							87	7									
8	See Supplemental Schedule										8									
9	<b>TOTAL Facility Related</b>					\$	\$ 9,063,831			\$ 524,270	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(4,471)	10									
11	Interst Income - Bldg Co.		X							(208)	11									
12											12									
13	See Supplemental Schedule										13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (4,679)	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 9,063,831			\$ 519,591	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 45,523 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2011 report.	\$	<b>425,078</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>409,831</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(15,247)</b>	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>423,310</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>	\$	<b>104</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>408,167</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2007	<b>325,273</b>	8
	2008	<b>328,537</b>	9
	2009	<b>387,946</b>	10
	2010	<b>404,836</b>	11
	2011	<b>403,152</b>	12

**2012 Accrual = \$403,152 x 1.05 = \$423,310**

**Allocated from NuCare: \$6,678**

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

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

# 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance At 87Th St. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042093

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>19-36-322-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>56,343.66</u>	\$ <u>56,343.66</u>
2.	<u>19-36-322-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>71,311.36</u>	\$ <u>71,311.36</u>
3.	<u>19-36-322-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>109,768.35</u>	\$ <u>109,768.35</u>
4.	<u>19-36-322-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>79,002.75</u>	\$ <u>79,002.75</u>
5.	<u>19-36-322-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>71,311.36</u>	\$ <u>71,311.36</u>
6.	<u>19-36-322-016-0000</u>	<u>Long Term Care Property</u>	\$ <u>10,439.34</u>	\$ <u>10,439.34</u>
7.	<u>19-36-322-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,570.40</u>	\$ <u>2,570.40</u>
8.	<u>19-36-322-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,405.27</u>	\$ <u>2,405.27</u>
9.	<u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>84,353.24</u>	\$ <u>4,749.52</u>
10.	<u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>84,353.24</u>	\$ <u>263.86</u>
<b>TOTALS</b>			\$ <u><u>571,858.97</u></u>	\$ <u><u>408,165.87</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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



Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,911 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.

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

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

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Facility, Allocation from 7257 N. Lincoln, and TOTALS.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 871h St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	210		1999	\$ 8,932,245	\$ 223,911	39	\$ 223,306	\$ (605)	\$ 3,056,124
5			1999	4,436					
6			1999	(204,169)					
7									
8									
<b>Improvement Type**</b>									
9	Various		1999	89,068		20	4,434	4,434	59,508
10	Various		2000	45,130		20	1,174	1,174	14,662
11	Various		2001	42,797		20	2,140	2,140	24,350
12	Various		2002	12,014		20	479	479	8,798
13	Various		2003	20,012		20	1,207	1,207	11,554
14	Various		2004	29,945		20	2,780	2,780	25,056
15	Various		2005	20,479		20	1,514	1,514	15,462
16	Various		2006	135,109		20	8,882	8,882	107,266
17	Various		2007	6,126		20	613	613	3,165
18	Various		2008	9,702		20	485	485	2,143
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

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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
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51								51
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53								53
54								54
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56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		852,891	77,695		42,646	(35,049)	201,496	67
68		137,807	4,689		5,170	481	38,611	68
69			158,957			(158,957)		69
70		\$ 10,133,592	\$ 465,252		\$ 294,830	\$ (170,422)	\$ 3,568,196	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 Renaissance At 87Th St.

# 0042093

Report Period Beginning:

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## 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>		\$ 10,133,592	\$ 465,252		\$ 294,830	\$ (170,422)	\$ 3,568,196	1
2	Remodel 1St Floor Showers, Replace Tile In 1&2	2010	4,217		20	422	422	1,265	2
3	Bathroom Remodeling, Remove And Install New Tiles, Grout And	2010	3,902		20	390	390	1,171	3
4	Remodel Bathrooms-Painting, Flooring, Tiling, Baseboards	2010	6,593		20	659	659	1,978	4
5	Bathroom Remodeling, Replace Drywalls And Tiles In 204,205,211	2010	2,900		20	290	290	846	5
6	Install 48 Openings For Cable Tv, 24 Outlets For Tv, Run Rg 6 Fo	2010	2,880		20	288	288	816	6
7	Konecto Plank Metroflor, Tuscania Florida Acorio-Breakroom Re	2010	3,664		20	366	366	1,038	7
8	Bathroom Remodeling 101, 104, 111, 120, 129, Remove/Replace Di	2010	2,900		20	290	290	822	8
9	Paint Hallway Walls, 2 Coats, 2 Tones	2010	3,800		20	380	380	1,077	9
10	Roof Repair	2010	4,375		20	438	438	1,240	10
11	Install 1 Carrier Chiller, Air Cooled Rotary Scroll Chiller	2010	73,799		20	7,380	7,380	15,375	11
12	Chi. Code Modification, Insulate Supply And Return Line, New Fl	2010	12,092		20	1,209	1,209	3,225	12
13	Bathroom Remodeling 103, 105, 110, 122, 123, Remove/Replace Di	2010	2,900		20	290	290	798	13
14	Staff Dining Rooms & Hallway- Patch, Sand, Repaint, Remove An	2010	3,150		20	315	315	866	14
15	1St Flr Resident Rooms-Furnish And Install 18 Upholstered Corni	2010	24,660		20	2,466	2,466	7,398	15
16	Remove Old Retaining Wall In Front Of Facility And Build A New	2010	6,800		20	680	680	1,870	16
17	Reimburse Bronzevill For 87Th Invoices Paid., 24 Fluorescent Lig	2010	3,520		20	352	352	968	17
18	Recover Rear Patio Canopy Using Old Frame With Ferrari Fabric	2010	8,279		20	828	828	2,277	18
19	Flr 1 Dining Rm- Remove Desk, New Kitchen Cabinet Doors Touc	2010	19,500		20	1,950	1,950	5,200	19
20	Furnish And Install Interior And Exterior Sliding Doors	2010	8,479		20	848	848	2,190	20
21	30 Yds Wallcovering Field, 60 Yds Accent Wallcovering	2010	2,535		20	254	254	655	21
22	Replace Defective Parts Of Walk-In Freezer In Kitchen Office, La	2010	3,408		20	341	341	852	22
23	Install 2, Washer/Condensor, New Air Vent, New Control On Pum	2010	3,298		20	330	330	825	23
24	Painting Of 3Rd Floor Patient Rooms And Bathrooms W/ 2 Coats	2010	19,253		20	1,925	1,925	4,653	24
25	Furnish 7 Cameras, 6 1/3 Sony Super Had Ccd, 1 Sony Had Ir Aut	2010	5,530		20	1,106	1,106	3,318	25
26	Remove Existing Ceiling Tile And Furnish And Install New Ceilin	2010	12,535		20	1,254	1,254	3,134	26
27	Paint Patient Rooms Floor 2	2010	19,253		20	1,925	1,925	4,332	27
28	Electrical Work In 10 Rooms	2010	3,480		20	348	348	783	28
29	Installation Of Wood Trims	2010	5,230		20	523	523	1,177	29
30	Painting Patient Rooms On 1St Floor	2010	18,120		20	1,812	1,812	3,926	30
31	High Output High Head Pump	2010	3,600		20	720	720	1,680	31
32	Deposit For Water Tank Expansion	2010	2,502		20	500	500	1,084	32
33	Walk In Cooler Repairs	2010	2,840		20	142	142	343	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,433,585	\$ 465,252		\$ 325,851	\$ (139,401)	\$ 3,645,374	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 Renaissance At 87Th St.

# 0042093

Report Period Beginning:

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## 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 12B, Carried Forward</b>		\$ 10,433,585	\$ 465,252		\$ 325,851	\$ (139,401)	\$ 3,645,374	1
2	Painting	2010	2,640		20	132	132	396	2
3	Repairs To Patio Crack In Concrete	2010	4,700		20	235	235	646	3
4	Electrical Work	2010	3,440		20	172	172	459	4
5	Asphalt Repair	2010	7,225		20	361	361	903	5
6	Labor And Materials To Replace 91 Bathroom Lights	2011	6,822		20	682	682	1,251	6
7	Fabricate 10 Floor Pad Cabinets For Patient Rooms To Match Col	2011	4,750		20	475	475	871	7
8	1St Flr Nurse Station- Custom Built In Cabinets And Refinish Ent	2011	4,580		20	458	458	840	8
9	3 Flrs Dining Rooms, Fabricate 90 Custom Made Window Railing	2011	7,500		20	750	750	1,375	9
10	Fabricate Molding For 137 Windows And Installed 6 New Window	2011	4,806		20	481	481	801	10
11	Custom Build 10 Floor Pad Cabinets For Patient Rooms	2011	4,750		20	475	475	831	11
12	2000 Lf Chair Rail Poplar 5/8' X 2 1/2 "	2011	2,746		20	275	275	412	12
13	Custome Build 53" Wall Cabinet, Beveled Edge Counter Top W/ 2	2011	5,725		20	573	573	859	13
14	10 Custom Build Floor Pad Cabinet For Patient Rooms, Color Ma	2011	4,750		20	475	475	871	14
15	10 Custom Built Cabinets Fir Floor Mattress Pads	2011	4,850		20	485	485	647	15
16	Installation Of 2 Pumps, Female Check Valve, Xoeller Control Par	2011	4,850		20	970	970	1,940	16
17	Window Treatments	2011	23,240		20	2,324	2,324	3,099	17
18	Painting/Lighting	2011	4,547		20	455	455	606	18
19	Wallpaper	2011	24,640		20	16,427	16,427	24,640	19
20	Electrical	2011	4,780		20	478	478	637	20
21	Millwork/Railings	2011	36,380		20	3,638	3,638	4,851	21
22	Measure And Design Cabinet Layout, Custom Build Tv Entertain	2011	13,540		20	1,354	1,354	1,467	22
23	Room Lot Signage	2011	11,206		20	1,121	1,121	1,214	23
24	Install Kitchen Sink, Faucet, New Water And Sewer Lines, Replac	2011	2,700		20	270	270	360	24
25	Wallcovering- Lobby-Prep Walls, Install New Vinyl	2011	2,572		20	257	257	343	25
26	Installing Power Outlets & Cable Tv In Rooms	2011	2,890		20	289	289	313	26
27	Wallcovering - Lobby - Prep Walls, Install & New Vynyl	2011	2,572		20	129	129	258	27
28	Installing Power Outlets & Cable Tv In Rooms	2011	2,890		20	145	145	290	28
29	Built In Cabinets, Side Storage	2012	3,585		20	717	717	717	29
30	Privacy Divder Walls & Door	2012	4,050		20	743	743	743	30
31	Privacy Divder Walls & Door	2012	5,270		20	878	878	878	31
32	Lights Building & Canopy	2012	3,200		20	160	160	160	32
33	Flooring - Vinyl	2012	12,123		20	866	866	866	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,667,904	\$ 465,252		\$ 363,099	\$ (102,153)	\$ 3,699,917	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,667,904	\$ 465,252		\$ 363,099	\$ (102,153)	\$ 3,699,917	1
2	Install Wiring For Touch Screen Monitors	2012	7,500		20	875	875	875	2
3	101 Undersink Protective Pipe Cover Plus 5I Offset Cover	2012	4,077		20	68	68	68	3
4	Word Door Specialists - 1/2" X 5" Saddle Threshold - Aluminum,	2012	4,890		20	82	82	82	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,684,372	\$ 465,252		\$ 364,123	\$ (101,129)	\$ 3,700,941	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

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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		\$ 10,684,372	\$ 465,252		\$ 364,123	\$ (101,129)	\$ 3,700,941	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)	\$ 10,684,372	\$ 465,252		\$ 364,123	\$ (101,129)	\$ 3,700,941	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 Renaissance At 87Th St.

# 0042093

Report Period Beginning:

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## 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	<b>Carpeting</b>	2004	2,093		20	105	105	1,716	9
10	<b>Various</b>	2005	96,496		20	4,825	4,825	63,728	10
11	<b>Built In Kitchen Unit/Cabinet/Table Legs And Sink</b>	2007	10,200		20	510	510	3,910	11
12	<b>3Rd Floor Replace Built-In Tv</b>	2007	2,700		20	135	135	1,013	12
13	<b>2Nd Floor Replace Built-In Tv</b>	2007	2,700		20	135	135	1,013	13
14	<b>Replace Built-In Cabinets And Credenza Unit</b>	2007	9,800		20	490	490	3,675	14
15	<b>2Nd Floor - Sink</b>	2007	4,800		20	240	240	1,800	15
16	<b>3Rd Floor - Assisted Bathing Area</b>	2007	5,200		20	260	260	1,950	16
17	<b>90 Yds Luminous Sage - Wall Covering</b>	2007	1,688		20	84	84	983	17
18	<b>150 Yds Tranquility Dandelion - Wall Covering</b>	2007	2,546		20	127	127	1,442	18
19	<b>2Nd Floor Dinning Room - Electrical</b>	2007	3,500		20	175	175	1,313	19
20	<b>3Rd Floor Dinning Room - Electrical</b>	2007	3,500		20	175	175	1,313	20
21	<b>2 New Wall Outlets - Wall Hungs Tvs</b>	2007	1,500		20	75	75	563	21
22	<b>Basement Corridor</b>	2007	2,750		20	138	138	1,033	22
23	<b>Cove Base</b>	2007	9,495		20	475	475	3,483	23
24	<b>120 Rigid Vinyl Guards</b>	2007	1,343		20	67	67	492	24
25	<b>20Pcs Surface Mounted Corner Guards</b>	2007	1,168		20	58	58	427	25
26	<b>Demolish Wall And Dispose Debris</b>	2007	8,000		20	400	400	2,933	26
27	<b>Vet Floor</b>	2007	9,150		20	458	458	3,357	27
28	<b>1 Beam Above Door</b>	2007	8,300		20	415	415	3,043	28
29	<b>Kitchen Cabinets</b>	2007	880		20	44	44	308	29
30	<b>Lobby/Large Main Office - Carpeting</b>	2007	8,578		20	429	429	3,656	30
31	<b>Door Upgrades &amp; R&amp;M</b>	2007	4,301		20	215	215	1,613	31
32	<b>Replace Ejector Pumps For Flood Control System</b>	2007	3,700		20	185	185	1,264	32
33	<b>Cabinets</b>	2007	10,320		20	516	516	3,784	33
34									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 Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

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**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 Continued</b>		\$	\$		\$	\$	\$	1
2	2Nd Floor - 34 Patients Rooms - Painting & Bumper Guards	2007	23,282		20	1,164	1,164	8,342	2
3	Vet Tiles For Bathroom	2008	4,656		20	233	233	1,165	3
4	Upholstered Cornice And Roller Shades; Remove Existing Window T	2008	8,647		20	432	432	2,161	4
5	Material & Labor For Power Supply & Switch For Airconditiong Syst	2008	5,726		20	286	286	1,431	5
6	Installation: Sprinkler, Ddc Valve, Expansion Tank & Anitfreeze	2008	7,665		20	383	383	1,916	6
7	Commerical Wood Door	2008	1,943		20	97	97	485	7
8	Painted Walls	2008	3,500		20	175	175	875	8
9	Commerical Wood Door	2008	1,772		20	89	89	444	9
10	Replacement Motor & Compressor And Refrigerant Of Freezer	2008	5,368		20	268	268	1,341	10
11	Telephone System Tadrian	2008	23,739		20	1,187	1,187	5,935	11
12	Motor Conversion	2008	2,965		20	148	148	741	12
13	Tadiran Ip X 500 Tel. System	2008	23,913		20	1,196	1,196	5,979	13
14	Remove Molded Drywall/Install New Mold Resistant Drywall In Hum	2008	850		20	43	43	214	14
15	130 Ft Of Sdr35 Drain Tile	2008	8,910		20	446	446	2,229	15
16	Painting And Touch Ups Plus Supplies	2008	1,645		20	82	82	411	16
17	Asphalt Repair Work Sealing And Striping	2008	7,600		20	380	380	1,900	17
18	Prime And Paint Outside Railings, Repair Walls, Paint Payroll Office,	2008	3,220		20	161	161	805	18
19	Painting Lower Level Conf Rm; Walls And Wallboard	2008	1,190		20	60	60	299	19
20	Painting - 2Nd Floor Doorframes And Dining Room	2008	2,970		20	149	149	744	20
21	Repair Walls And Paint Activity Office On 2Nd Floor	2008	1,260		20	63	63	315	21
22	Plaster, Prime, And Paint 3Rd Floor Dining Rm Walls, Window Sills,	2008	10,600		20	530	530	2,650	22
23	Paint Basement Offices Including Removal Of Borders, Plastering Hol	2008	1,280		20	64	64	320	23
24	Part & Labor to repair Fire Sprinkler System	2009	4,224		20	211	211	844	24
25	Core Glosswhite Tile	2009	2,753		20	138	138	552	25
26	Paint & Remodeling of 7 Shower Rooms	2009	17,363		20	868	868	3,472	26
27	Flooring	2011	194,042		20	9,702	9,702	19,404	27
28	Casework/Countertops	2011	68,125		20	3,406	3,406	6,812	28
29	Demolition/Carpentry	2011	74,500		20	3,725	3,725	7,450	29
30	Buildout	2011	65,045		20	3,252	3,252	6,504	30
31	Wallpaper/Paint	2011	59,430		20	2,972	2,972	5,944	31
32	Depreciation			77,695			(77,695)		32
33									33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ 852,891	\$ 77,695		\$ 42,646	\$ (35,049)	\$ 201,496	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>Related Party Information</b>	\$	\$		\$	\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from 7257 N. Lincoln Ave.	2004	81,079	2,079	35	2,317	238	21,139	3
4	Allocated from Clinical Consulting Services	2004	4,504	115	35	129	14	1,174	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from 7257 N. Lincoln Ave.	2005	7,391	52	20	477	425	3,487	9
10	Allocated from 7257 N. Lincoln Ave.	2004	1,611		20	81	81	685	10
11									11
12	Allocated from Clinical Consulting Services	2005	411	3	20	27	24	194	12
13	Allocated from Clinical Consulting Services	2004	90		20	4	4	38	13
14									14
15	Allocated from NuCare Services	2003	733	42	20	37	(5)	334	15
16	Allocated from NuCare Services	2004	14,877	850	20	745	(105)	6,487	16
17	Allocated from NuCare Services	2005	882	50	20	44	(6)	346	17
18	Allocated from NuCare Services	2006	1,196	68	20	60	(8)	381	18
19	Allocated from NuCare Services	2008	1,261	72	20	63	(9)	268	19
20	Allocated from NuCare Services	2009	20,296	1,159	20	1,015	(144)	3,664	20
21	Allocated from NuCare Services	2010	3,119	178	20	156	(22)	391	21
22	Allocated from NuCare Services	2011	169	10	20	8	(2)	16	22
23	Allocated from NuCare Services	2012	188	11	20	7	(4)	7	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 Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 137,807	\$ 4,689		\$ 5,170	\$ 481	\$ 38,611	34

SEE ACCOUNTANTS' COMPILATION REPORT

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



XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,778,218	\$ 50,171	\$ 194,433	\$ 144,262	10	\$ 1,571,652	71
72	Current Year Purchases	113,812	598	6,587	5,989	10	6,587	72
73	Fully Depreciated Assets	388,207		7	7	10	388,205	73
74								74
75	TOTALS	\$ 2,280,236	\$ 50,769	\$ 201,026	\$ 150,257		\$ 1,966,443	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Nucare	2012	\$ 554	\$ 32	\$ 111	\$ 79	5	\$ 268	76
77										77
78										78
79										79
80	TOTALS			\$ 554	\$ 32	\$ 111	\$ 79		\$ 268	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)	\$ 13,118,284	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 516,053	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 565,261	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 49,208	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,667,652	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5	Storage Rental				3,434			5
6	Allocated from NuCare (Parking Lot)				409			6
7	TOTAL				\$ 3,843			7

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

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

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

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 28,424 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	Allocated from CCS		\$ _____	\$ 328	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 328	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 523,134	\$		\$ 523,134	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			161,327			161,327	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			577,883			577,883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				555,355		555,355	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					17,687	188,020		205,707	13
14	TOTAL			\$		\$ 1,280,031	\$ 743,375		\$ 2,023,406	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning: 01/01/12

Ending: 12/31/12

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 6,508	\$ 259,690	1
2	Cash-Patient Deposits	16,993	16,993	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,607,485	3,504,090	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,176	160,819	6
7	Other Prepaid Expenses	8,869	8,869	7
8	Accounts Receivable (owners or related parties)	2,288,483	2,288,483	8
9	Other(specify): <u>See Attached Schedule</u>	10,582	339,990	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,088,096	\$ 6,578,934	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		143,613	13
14	Buildings, at Historical Cost		8,761,754	14
15	Leasehold Improvements, at Historical Cost	885,563	1,655,171	15
16	Equipment, at Historical Cost	971,681	2,275,903	16
17	Accumulated Depreciation (book methods)	(1,088,926)	(5,623,615)	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>	126	356,873	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 768,444	\$ 7,569,699	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,856,540	\$ 14,148,633	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 2,414,760	\$ 2,414,759	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,039	37,039	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	521,073	521,073	30
31	Accrued Taxes Payable (excluding real estate taxes)	65,349	65,349	31
32	Accrued Real Estate Taxes(Sch.IX-B)		423,310	32
33	Accrued Interest Payable		43,355	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	160,807	160,807	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,199,028	\$ 3,665,692	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		(94,032)	39
40	Mortgage Payable		9,157,863	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 9,063,831	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,199,028	\$ 12,729,523	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,657,512	\$ 1,419,110	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,856,540	\$ 14,148,633	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>4,008,725</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Hazard Insurance Restatement</b>	(133,137)	<b>3</b>
<b>4</b>	<b>Rounding</b>	4	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,875,592</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(218,080)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(218,080)</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>3,657,512</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning: 01/01/12

Ending:

12/31/12

**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		2	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,825,720	1
2	Discounts and Allowances for all Levels	(1,529,419)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,296,301	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,601,738	6
7	Oxygen	44,311	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,646,049	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,004,080	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,917	19
20	Radiology and X-Ray	84,629	20
21	Other Medical Services	198,727	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,324,353	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	10	24
25	Interest and Other Investment Income***	4,471	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,481	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	516	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 516	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,271,700	30

2		3	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,806,597	31
32	Health Care	5,690,380	32
33	General Administration	4,773,903	33
<b>B. Capital Expense</b>			
34	Ownership	1,556,525	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,284,485	35
36	Provider Participation Fee	377,890	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,489,780	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(218,080)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (218,080)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 6,855,947	44
45	Private Pay - Net Inpatient Revenue	590,245	45
46	Medicare - Net Inpatient Revenue	2,550,297	46
47	Other-(specify) CCHHS	43,836	47
48	Other-(specify) Managed Care/Hospice	1,255,976	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 11,296,301	49

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,848	2,097	\$ 103,133	\$ 49.18	1
2	Assistant Director of Nursing	1,606	2,056	99,469	48.38	2
3	Registered Nurses	29,925	31,711	969,248	30.57	3
4	Licensed Practical Nurses	61,784	66,083	1,715,219	25.96	4
5	CNAs & Orderlies	128,599	137,825	1,524,575	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,036	9,613	100,651	10.47	8
9	Activity Director	2,114	2,266	54,855	24.21	9
10	Activity Assistants	9,863	10,729	113,408	10.57	10
11	Social Service Workers	12,924	13,897	230,130	16.56	11
12	Dietician	1,455	1,599	32,054	20.05	12
13	Food Service Supervisor	2,420	2,665	53,490	20.07	13
14	Head Cook	3,738	4,152	51,277	12.35	14
15	Cook Helpers/Assistants	20,031	21,744	210,259	9.67	15
16	Dishwashers					16
17	Maintenance Workers	4,355	4,646	102,390	22.04	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,975	2,097	114,424	54.57	20
21	Assistant Administrator					21
22	Other Administrative	160	160	11,086	69.29	22
23	Office Manager	1,955	2,121	63,052	29.73	23
24	Clerical	11,214	12,646	246,220	19.47	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	1,026	1,127	34,663	30.76	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,745	5,986	142,893	23.87	33
34	TOTAL (lines 1 - 33)	311,773	335,220	\$ 5,972,496 *	\$ 17.82	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	328	\$ 15,616	01-03	35
36	Medical Director	Monthly	29,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	368	9,707	10-03	38
39	Pharmacist Consultant	Monthly	13,503	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				45
46	Other(specify)				46
47	Medical Consultant	Monthly	81,700	10-03	47
48					48
49	TOTAL (lines 35 - 48)	696	\$ 150,026		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Daniel Johnson	Administrator	0.00%	\$ 114,424	Workers' Compensation Insurance	\$ 355,237	IDPH License Fee	\$ 1,078	
Sondra Mixdorf	Reg. Dir. Of Operat	0.00%	11,086	Unemployment Compensation Insurance	231,290	Advertising: Employee Recruitment	1,242	
				FICA Taxes	452,209	Health Care Worker Background Check		
				Employee Health Insurance	219,481	(Indicate # of checks performed 949 )	12,187	
				Employee Meals	28,987	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,472	
				City Payroll Tax	3,212	Licenses & Inspections	5,876	
				Other Employee Benefits	111,541	Advertising & Promotions	50,016	
				Dental Insurance	2,047	Allocated from NuCare	415	
				Pension Expense	37,666	See Supplemental Schedule	80	
				401K Employee	1,988	Less: Public Relations Expense	( )	
						Non-allowable advertising	(50,016)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,510	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,443,658	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,350	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
NuCare Services - Bookkeeping Fees			\$ 752,000				Out-of-State Travel	\$
Clinical Consulting Services - Administrative Fees			61,929					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 813,929	TOTAL		\$	Seminar Expense	11,147
							Allocated from Nucare	108
							Allocated from CCS	261
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 160,325				TOTAL	\$ 11,516

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

\*\*See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Renaissance At 87Th St.

# 0042093

Report Period Beginning:

01/01/12

Ending:

12/31/12

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC \$19,511
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,907 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. \$ 377,890  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 28,987 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT