FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0042093

Facility Name: The Renaissance at 87th St

Address: 2940 West 87th St (Number) | Chicago (City) | 60652 (Zip Code)

County: Cook

Telephone Number: (773) 434-8787 **Fax #** (773) 434-8717

HFS ID Number:

Date of Initial License for Current Owners: 7/19/1999

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	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	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			18,237	18,237	8
9	SNF/PED					9
10	ICF	43,491	2,912	3,402	49,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,491	2,912	21,639	68,042	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.77%

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 [X]

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

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 [X] Date New Construction NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 10,889

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	361,857	84,685	17,020	463,562		463,562		463,562			1
2	Food Purchase		347,390		347,390	(31,116)	316,274	(149)	316,125			2
3	Housekeeping		7,600	361,342	368,942		368,942		368,942			3
4	Laundry		33,936	149,346	183,282		183,282		183,282			4
5	Heat and Other Utilities			240,727	240,727		240,727	(5,131)	235,596			5
6	Maintenance	108,270	59,020	132,924	300,214		300,214	36,708	336,922			6
7	Other (specify):*							396	396			7
8	TOTAL General Services	470,127	532,631	901,359	1,904,117	(31,116)	1,873,001	31,823	1,904,824			8
	B. Health Care and Programs											
9	Medical Director			6,750	6,750		6,750		6,750			9
10	Nursing and Medical Records	4,700,276	499,563	91,176	5,291,015		5,291,015	(1,972)	5,289,043			10
10a	Therapy	170,088	(1,347)		168,741		168,741		168,741			10a
11	Activities	180,930	32,044	1,760	214,734		214,734		214,734			11
12	Social Services	228,745			228,745		228,745		228,745			12
13	CNA Training											13
14	Program Transportation			2,118	2,118		2,118		2,118			14
15	Other (specify):*							1,651	1,651			15
16	TOTAL Health Care and Programs	5,280,039	530,260	101,804	5,912,103		5,912,103	(321)	5,911,782			16
	C. General Administration											
17	Administrative	192,415		1,153,654	1,346,069		1,346,069	(1,114,088)	231,981			17
18	Directors Fees											18
19	Professional Services			201,353	201,353	(27,392)	173,961	(18,757)	155,204			19
20	Dues, Fees, Subscriptions & Promotions			127,714	127,714		127,714	(71,578)	56,136			20
21	Clerical & General Office Expenses	329,943	40,613	742,340	1,112,896		1,112,896	(468,701)	644,195			21
22	Employee Benefits & Payroll Taxes			1,213,143	1,213,143	31,116	1,244,259		1,244,259			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,773	7,773		7,773	65	7,838			24
25	Other Admin. Staff Transportation			721	721		721	5,511	6,232			25
26	Insurance-Prop.Liab.Malpractice			759,249	759,249		759,249	(101,272)	657,977			26
27	Other (specify):*							20,877	20,877			27
28	TOTAL General Administration	522,358	40,613	4,205,947	4,768,918	3,724	4,772,642	(1,747,943)	3,024,699			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,272,524	1,103,504	5,209,110	12,585,138	(27,392)	12,557,746	(1,716,440)	10,841,306			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Renaissance at 87th St #0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			137,177	137,177		137,177	406,561	543,738			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,764	149,764		149,764	230,800	380,564			32
33	Real Estate Taxes					27,392	27,392	405,993	433,385			33
34	Rent-Facility & Grounds			1,854,006	1,854,006		1,854,006	(1,848,386)	5,620			34
35	Rent-Equipment & Vehicles			47,619	47,619		47,619	2,582	50,201			35
36	Other (specify):*							46,667	46,667			36
37	TOTAL Ownership			2,188,566	2,188,566	27,392	2,215,958	(755,783)	1,460,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		758,765	2,281,849	3,040,614		3,040,614	(21,548)	3,019,066			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			459,836	459,836		459,836		459,836			42
43	Other (specify):*	189,453		6,294	195,747		195,747	(195,747)	(0)			43
44	TOTAL Special Cost Centers	189,453	758,765	2,747,979	3,696,197		3,696,197	(217,295)	3,478,902			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,461,977	1,862,269	10,145,655	18,469,901		18,469,901	(2,689,518)	15,780,383			45

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(7,889)	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	65,090	30		9
10	Interest and Other Investment Income	(39,429)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	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	(15,998)	21		18
19	Entertainment	(1,014)	24		19
20	Contributions	(21,056)	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	(520,656)	21		24
25	Fund Raising, Advertising and Promotional	(48,758)	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	(524,892)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,114,751)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	(1,574,767)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,574,767)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,689,518)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

The Renaissance at 87th St

ID# 0042093

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Needs	$ (13,555)	10	1
2	Bank Charges	(17,836)	21	2
3	Sequestration Fees	(133,191)	21	3
4	Prior Year Insurance	(113,266)	26	4
5	Medical Records Copy	(350)	10	5
6	Jury Duty Income	(52)	10	6
7	Annual Report	(279)	20	7
8	Collections	(585)	21	8
9	Web Site	(454)	21	9
10	Out of Period Seminars	(139)	24	10
11	Guest Relations Salary	(65,739)	43	11
12	Building Company - Legal Fees	(250)	19	12
13	Building Company - Fees	(100)	21	13
14	Building Company - Accounting	(9,500)	19	14
15	Building Company - Amortization	(4,185)	36	15
16	Building Company - Additional R&M	9,792	06	16
17	Additional R&M	13,884	06	17
18	COPE Dues	(2,907)	20	18
19	Non-Allowable Legal	(27,750)	19	19
20	Marketing Salary	(123,714)	43	20
21	Gain on Disposal of Assets	(11,185)	30	21
22	Refunds - Consultant Services	(4,088)	10	22
23	Building Company - Capitalized R&M	(13,150)	06	23
24	Non-Allowable Expense	(6,294)	43	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(524,892)		49

The Renaissance at 87th St

ID# 0042093

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Renaissance at 87th St # 0042093 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(149)											(149)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,889)		2,758									(5,131)	5
6	Maintenance	10,526	13,150	13,032									36,708	6
7	Other (specify):*			396									396	7
8	**TOTAL General Services**	2,488	13,150	16,185									31,823	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(18,045)		18,639					(2,566)				(1,972)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,651									1,651	15
16	**TOTAL Health Care and Programs**	(18,045)		20,290					(2,566)				(321)	16
	C. General Administration													
17	Administrative			(1,126,588)				12,500					(1,114,088)	17
18	Directors Fees													18
19	Professional Services	(37,500)	9,750	8,368				625					(18,757)	19
20	Fees, Subscriptions & Promotions	(73,000)		1,422									(71,578)	20
21	Clerical & General Office Expenses	(688,819)	100	215,665				4,354					(468,701)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,153)		1,218									65	24
25	Other Admin. Staff Transportation			5,511									5,511	25
26	Insurance-Prop.Liab.Malpractice	(113,266)	11,366	628									(101,272)	26
27	Other (specify):*			19,388				1,489					20,877	27
28	**TOTAL General Administration**	(913,739)	21,216	(874,388)				18,968					(1,747,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(929,295)	34,366	(837,913)				18,968	(2,566)				(1,716,440)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Renaissance at 87th St # 0042093 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	53,905	343,365	9,291									406,561	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(39,429)	267,982	2,247									230,800	32
33	Real Estate Taxes		402,291	3,702									405,993	33
34	Rent-Facility & Grounds		(1,848,806)	420									(1,848,386)	34
35	Rent-Equipment & Vehicles			2,582									2,582	35
36	Other (specify):*	(4,185)	50,852										46,667	36
37	**TOTAL Ownership**	10,291	(784,316)	18,242									(755,783)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(11,350)	(2,498)			(7,700)				(21,548)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(195,747)											(195,747)	43
44	**TOTAL Special Cost Centers**	(195,747)			(11,350)	(2,498)			(7,700)				(217,295)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,114,751)	(749,950)	(819,671)	(11,350)	(2,498)		18,968	(10,266)				(2,689,518)	45

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,848,806	Renaissance at Beverly LP	100.00%	$	$ (1,848,806)	1
2	V	32	Interest	240	Renaissance at Beverly LP	100.00%	268,222	267,982	2
3	V	19	Legal Fees		Renaissance at Beverly LP	100.00%	250	250	3
4	V	06	Linen Replacement		Renaissance at Beverly LP	100.00%	13,150	13,150	4
5	V	36	MIP Expense		Renaissance at Beverly LP	100.00%	46,667	46,667	5
6	V	26	Insurance		Renaissance at Beverly LP	100.00%	11,366	11,366	6
7	V	21	Fees		Renaissance at Beverly LP	100.00%	100	100	7
8	V	19	Accounting Fees		Renaissance at Beverly LP	100.00%	9,500	9,500	8
9	V	33	Real Estate Taxes		Renaissance at Beverly LP	100.00%	402,291	402,291	9
10	V	30	Depreciation		Renaissance at Beverly LP	100.00%	343,365	343,365	10
11	V	36	Amortization		Renaissance at Beverly LP	100.00%	4,185	4,185	11
12	V								12
13	V								13
14	Total			$ 1,849,046			$ 1,099,096	$ * (749,950)	14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 2,758	$ 2,758	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	4,470	4,470	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,561	8,561	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	396	396	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	18,639	18,639	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,651	1,651	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	27,066	27,066	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	8,368	8,368	22
23	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,422	1,422	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	181,666	181,666	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	33,999	33,999	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,218	1,218	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	5,511	5,511	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	628	628	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	19,388	19,388	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	9,291	9,291	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,247	2,247	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	3,702	3,702	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	420	420	33
34	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	2,582	2,582	34
35	V								35
36	V	17	BOOKKEEPING FEES	1,153,654	NUCARE SERVICES CORP.	100.00%		(1,153,654)	36
37	V								37
38	V								38
39	Total			$ 1,153,654			$ 333,983	$ * (819,671)	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & MEDICAL SUPPLIES	$ 122,913	INTEGRA HEALTHCARE EQUIPMENT		$ 111,563	$ (11,350)	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			$ 122,913			$ 111,563	$ * (11,350)	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	RESPIRATORY SERVICES	$ 11,985	INTEGRA RESPIRATORY SERVICES LLC		$ 9,487	$ (2,498)	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			$ 11,985			$ 9,487	$ * (2,498)	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS COMPENSATION	$ 143,468	MAPLE LEAF INSURANCE	100.00%	$ 143,468	$	15
16	V	26	LIABILITY INSURANCE	488,790	MAPLE LEAF INSURANCE	100.00%	488,790		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			$ 632,258			$ 632,258	$ *	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR FINANCIAL SERVICES CORP.	100.00%	$ 12,500	$ 12,500	15
16	V	19	PROFESSIONAL FEES		JLR FINANCIAL SERVICES CORP.	100.00%	625	625	16
17	V	21	OFFICE		JLR FINANCIAL SERVICES CORP.	100.00%	4,354	4,354	17
18	V	27	EMPLOYEE BENEFITS		JLR FINANCIAL SERVICES CORP.	100.00%	1,489	1,489	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			$			$ 18,968	$ * 18,968	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	AMBULANCE SERVICES	$ 11,050	LIFELINE AMBULANCE		$ 8,484	$ (2,566)	15
16	V	39	AMBULANCE SERVICES	33,163	LIFELINE AMBULANCE		25,463	(7,700)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,213			$ 33,947	$ * (10,266)	39

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	4.9000%	CALIFORNIA GARDENS CORP.	CHICAGO	RENAISSANCE AT BEVERLY LP		BUILDING CO.	1
2	MARSHALL A. MAUER	6.2500%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	MAPLE LEAF INSURANCE	GRAND CAYMAN	LIABILITY INSURANCE	2
3	MAURICE I. AARON	4.2500%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	KFT SERVICES LLC	LINCOLNWOOD	MANAGEMENT CO.	3
4	ORA AARON	2.0000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	DRAKE LOUIS ENTERPRISE	LINCOLNWOOD	MANAGEMENT CO.	4
5	ORIOLE TRUST	4.9500%	JACKSON CORP.	CHICAGO	JLR FINANCIAL SERVICES COI	LINCOLNWOOD	FINANCIAL	5
6	RAJCHENBACH FAMILY TRUST	25.0000%	MONROE CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	6
7	ROBERT HARTMAN FAMILY TRUST	20.0500%	RENAISSANCE EAST	MESA, ARIZONA	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	7
8	SUSAN L. STERN	4.9000%	RENAISSANCE VILLAGE AL	MESA, ARIZONA	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	8
9	MARK HOLLANDER DISCRETIONARY TRUST	8.3333%	RENAISSANCE VILLAGE IL	MESA, ARIZONA	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	9
10	SHARON HOLLANDER DISCRETIONARY TRUST	8.3333%	RENAISSANCE WEST	MESA, ARIZONA	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	10
11	FEIGE C. KNOBEL DISCRETIONARY TRUST	8.3334%	RENAISSANCE PARK SOUTH LLC	CHICAGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY	11
12	TODD ANDREW STERN 2001 TRUST	0.9000%	ARIA POST ACUTE CARE	HILLSIDE				12
13	EVAN MICHAEL STERN 2005 TRUST	0.9000%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO				13
14	JONATHAN BRYAN STERN 2001 TRUST	0.9000%	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 The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Relative	Administrative	0.00%	See Attached	6.00	10.00%	Alloc. Sal.	$ 12,500	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	$ 12,500		13

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

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,239,904	17	$ 44,608	$	76,650	$ 2,758	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	72,310	72,310	76,650	4,470	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,239,904	17	138,492		76,650	8,561	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,239,904	17	6,405		76,650	396	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	301,506	301,506	76,650	18,639	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS	1,239,904	17	26,708		76,650	1,651	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	437,828	437,828	76,650	27,066	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,239,904	17	135,365		76,650	8,368	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,239,904	17	23,010		76,650	1,422	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,239,904	17	2,938,655	2,938,655	76,650	181,666	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,239,904	17	549,976		76,650	33,999	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,239,904	17	19,695		76,650	1,218	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,239,904	17	89,139		76,650	5,511	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,239,904	17	10,164		76,650	628	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,239,904	17	313,624		76,650	19,388	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,239,904	17	150,292		76,650	9,291	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,239,904	17	36,349		76,650	2,247	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,239,904	17	59,877		76,650	3,702	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,239,904	17	6,796		76,650	420	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,239,904	17	41,766		76,650	2,582	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,402,565	$ 3,750,299		$ 333,983	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 111,563	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					$	$		$ 111,563	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: Integra Respiratory Services LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	RESPIRATORY SERVICES	DIRECT ALLOCATION			$	$		$ 9,487	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					$	$		$ 9,487	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: Maple Leaf Insurance
Street Address: PO Box 69, 720 West Bay Rd
City / State / Zip Code: Grand Cayman, KY1-1102
Phone Number: (
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	WORKERS COMPENSATION	DIRECT ALLOCATION			$	$		$ 143,468	1
2	26	LIABILITY INSURANCE	DIRECT ALLOCATION						488,790	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					$	$		$ 632,258	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	48	9	$ 100,000	$ 100,000	6	$ 12,500	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	9	5,000		6	625	2
3	21	OFFICE	AVG. HOURS WORKED	48	9	34,828	34,828	6	4,354	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	48	9	11,911		6	1,489	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					$ 151,739	$ 134,828		$ 18,968	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

Name of Related Organization: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	AMBULANCE	DIRECT ALLOCATION			$	$		$ 8,484	1
2	39	AMBULANCE	DIRECT ALLOCATION						25,463	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					$	$		$ 33,947	25

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				
	A. Directly Facility Related											
	Long-Term											
1	Mortgage Payable		X	Building			$	$ 9,349,952			$ 268,222	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				3,484,686			149,763	6
7	Allocated from NuCare Services Corp.										2,247	7
8												8
9	TOTAL Facility Related						$	$ 12,834,638			$ 420,232	9
	B. Non-Facility Related*											
10	Interest Income		X								(39,429)	10
11	Interest Income - Bldg Co.		X								(239)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (39,668)	14
15	TOTALS (line 9+line14)						$	$ 12,834,638			$ 380,565	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 46,667** **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.)**

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 468,764	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.)		$ 428,607	2
3. Under or (over) accrual (line 2 minus line 1).		$ (40,157)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 446,150	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 27,392	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 61,734 **For** 2011 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 433,385	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	387,946	8
	2010	404,836	9
	2011	403,152	10
	2012	446,442	11
	2013	424,905	12

2014 Accrual: $424,905 x 1.05 = $446,150

Allocated from NuCare: $3,702

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Renaissance at 87th St COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042093

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-36-322-011-0000	Long Term Care Property	$ 59,391.74	$ 59,391.74
2.	19-36-322-012-0000	Long Term Care Property	$ 75,091.88	$ 75,091.88
3.	19-36-322-013-0000	Long Term Care Property	$ 115,507.12	$ 115,507.12
4.	19-36-322-014-0000	Long Term Care Property	$ 83,174.95	$ 83,174.95
5.	19-36-322-015-0000	Long Term Care Property	$ 75,091.88	$ 75,091.88
6.	19-36-322-016-0000	Long Term Care Property	$ 11,120.27	$ 11,120.27
7.	19-36-322-017-0000	Long Term Care Property	$ 2,850.31	$ 2,850.31
8.	19-36-322-018-0000	Long Term Care Property	$ 2,676.85	$ 2,676.85
9.	10-27-319-028-0000	Home Office Allocation	$ 89,368.57	$ 3,701.55
10.			$	$
		TOTALS	$ 514,273.57	$ 428,606.55

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Renaissance at 87th St COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042093

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,162	1994	$ 143,613	1
2	Allocated from 7257 N. Lincoln Avenue			6,627	2
3	TOTALS	51,162		$ 150,240	3

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210			1999	$ 8,930,998	$ 226,835	39	$ 223,306	$ (3,529)	$ 3,502,736	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	89,068		20	4,434	4,434	68,377	9
10	Various			2000	45,130		20	1,174	1,174	17,010	10
11	Various			2001	40,213		20	2,011	2,011	26,875	11
12	Various			2002	12,014		20	344	344	9,485	12
13	Various			2003	20,012		20	795	795	13,310	13
14	Various			2004	27,005		20	962	962	25,907	14
15	Various			2005	16,125		20	696	696	13,676	15
16	Various			2006	109,609		20	8,084	8,084	98,449	16
17	Various			2010	320,346		20	31,663	31,663	142,552	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		783,631	76,109		39,182	(36,927)	236,525	67
68	Related Party Allocations (Pages 12H & 12I)		110,798	4,482		4,288	(194)	38,881	68
69	Financial Statement Depreciation			125,992			(125,992)		69
70	TOTAL (lines 4 thru 69)		$ 10,504,949	$ 433,418		$ 316,938	$ (116,480)	$ 4,193,782	70

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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 12A, Carried Forward		$ 10,504,949	$ 433,418		$ 316,938	$ (116,480)	$ 4,193,782	1
2	Labor And Materials To Replace 91 Bathroom Lights	2011	6,822		20	682	682	2,615	2
3	1St Flr Nurse Station- Custom Built In Cabinets And Refinish Entr	2011	4,580		20	458	458	1,756	3
4	3 Flrs Dining Rooms, Fabricate 90 Custom Made Window Railing,	2011	7,500		20	750	750	2,875	4
5	Fabricate Molding For 137 Windows And Installed 6 New Window	2011	4,806		20	481	481	1,762	5
6	Custom Build 10 Floor Pad Cabinets For Patient Rooms	2011	4,750		20	475	475	1,781	6
7	2000 Lf Chair Rail Poplar 5/8' X 2 1/2 "	2011	2,746		20	275	275	961	7
8	Custome Build 53" Wall Cabinet, Beveled Edge Counter Top W/ 2	2011	5,725		20	573	573	2,004	8
9	10 Custom Build Floor Pad Cabinet For Patient Rooms, Color Mat	2011	4,750		20	475	475	1,821	9
10	10 Custom Built Cabinets Fir Floor Mattress Pads	2011	4,850		20	485	485	1,617	10
11	Window Treatments	2011	23,240		20	2,324	2,324	7,747	11
12	Painting/Lighting	2011	4,547		20	455	455	1,516	12
13	Wallpaper	2011	24,640		20			24,640	13
14	Electrical	2011	4,780		20	478	478	1,593	14
15	Millwork/Railings	2011	36,380		20	3,638	3,638	12,127	15
16	Measure And Design Cabinet Layout, Custom Build Tv Entertainn	2011	10,000		20	1,000	1,000	3,083	16
17	Room Lot Signage	2011	11,206		20	1,121	1,121	3,455	17
18	Install Kitchen Sink, Faucet, New Water And Sewer Lines, Replace	2011	2,700		20	270	270	900	18
19	Wallcovering- Lobby-Prep Walls, Install New Vinyl	2011	2,572		20	257	257	857	19
20	Installing Power Outlets & Cable Tv In Rooms	2011	2,890		20	289	289	891	20
21	Cabinets	2012	3,585		20	717	717	2,151	21
22	Divider Walls	2012	4,050		20	810	810	2,363	22
23	Divider Walls	2012	4,570		20	914	914	2,590	23
24	Lighting - Building And Parking Lot	2012	3,200		20	213	213	587	24
25	Flooring - Vinyl	2012	12,123		20	1,732	1,732	4,330	25
26	Install Wiring For Touch Screen Monitors	2012	7,500		20	1,500	1,500	3,875	26
27	101 Undersink Protective Pipe Cover Plus 5I Offset Cover	2012	4,077		20	408	408	883	27
28	Word Door Specialists - 1/2" X 5" Saddle Threshold - Aluminum, S	2012	4,890		20	489	489	1,060	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12B, Carried Forward		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	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)		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	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)		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12D, Carried Forward		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	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)		$ 10,718,428	$ 433,418		$ 338,205	$ (95,213)	$ 4,285,621	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2005	96,496		20	4,825	4,825	73,378	9
10	Built In Kitchen Unit/Cabinet/Table Legs And Sink	2007	10,200		20	510	510	4,930	10
11	Replace Built-In Cabinets And Credenza Unit	2007	9,800		20	490	490	4,655	11
12	2Nd Floor - Sink	2007	4,800		20	240	240	2,280	12
13	3Rd Floor - Assisted Bathing Area	2007	5,200		20	260	260	2,470	13
14	150 Yds Tranquility Dandelion - Wall Covering	2007	2,546		20	127	127	1,696	14
15	2Nd Floor Dinning Room - Electrical	2007	3,500		20	175	175	1,663	15
16	3Rd Floor Dinning Room - Electrical	2007	3,500		20	175	175	1,663	16
17	Basement Corridor	2007	2,750		20	138	138	1,309	17
18	Lobby/Large Main Office - Carpeting	2007	8,578		20	429	429	4,514	18
19	Door Upgrades & R&M	2007	4,301		20	215	215	2,043	19
20	Replace Ejector Pumps For Flood Control System	2007	3,700		20	185	185	1,634	20
21	Vct Tiles For Bathroom	2008	4,656		20	233	233	1,631	21
22	Upholestered Cornice And Roller Shades; Remove Existing Windo	2008	8,647		20	432	432	3,025	22
23	Material & Labor For Power Supply & Switch For Airconditiong S	2008	5,726		20	286	286	2,003	23
24	Installation: Sprinkler, Ddc Valve, Expansion Tank & Anitfreeze	2008	7,665		20	383	383	2,682	24
25	Replacement Motor & Compressor And Refrigerant Of Freezer	2008	5,368		20	268	268	1,877	25
26	Telephone System Tadrian	2008	23,739		20	1,187	1,187	8,309	26
27	Motor Conversion	2008	2,965		20	148	148	1,037	27
28	130 Ft Of Sdr35 Drain Tile	2008	8,910		20	446	446	3,121	28
29	Asphalt Repair Work Sealing And Striping	2008	7,600		20	380	380	2,660	29
30	Prime And Paint Outside Railings, Repair Walls, Paint Payroll Off	2008	3,220		20	161	161	1,127	30
31	Painting - 2Nd Floor Doorframes And Dining Room	2008	2,970		20	149	149	1,042	31
32	Plaster, Prime, And Paint 3Rd Floor Dining Rm Walls, Window Si	2008	10,600		20	530	530	3,710	32
33	Part & Labor to repair Fire Sprinkler System	2009	4,224		20	211	211	1,266	33
34	TOTAL (lines 1 thru 33)		$ 251,661	$		$ 12,583	$ 12,583	$ 135,725	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 251,661	$		$ 12,583	$ 12,583	$ 135,725	1
2	Core Glosswhite Tile	2009	2,753		20	138	138	828	2
3	Paint & Remodeling of 7 Shower Rooms	2009	17,363		20	868	868	5,208	3
4	Flooring	2011	194,042		20	9,702	9,702	38,808	4
5	Casework/Countertops	2011	68,125		20	3,406	3,406	13,624	5
6	Demolition/Carpentry	2011	74,500		20	3,725	3,725	14,900	6
7	Buildout	2011	65,045		20	3,252	3,252	13,008	7
8	Wallpaper/Paint	2011	59,430		20	2,972	2,972	11,888	8
9	VCT Tile Removal & Installation-Resident Rooms 1st,2nd & 3rd FL	2014	44,000		20	2,200	2,200	2,200	9
10	Install New Vinyl Base in Resident Rooms with New Tiles-1,2&3rd Fl	2014	3,900		20	195	195	195	10
11	2nd Floor - Replaced Wood Door and Window	2014	2,812		20	141	141	141	11
12									12
13									13
14									14
15									15
16	Depreciation			76,109			(76,109)		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)		$ 783,631	$ 76,109		$ 39,182	$ (36,927)	$ 236,525	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Ave.	2004	59,643	1,529	20	1,704	175	18,958	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from NuCare Services	2003	724	47	20	36	(11)	403	9
10	Allocated from NuCare Services	2004	14,701	962	20	736	(226)	7,883	10
11	Allocated from NuCare Services	2005	872	57	20	44	(13)	429	11
12	Allocated from NuCare Services	2006	1,182	77	20	59	(18)	494	12
13	Allocated from NuCare Services	2008	1,246	82	20	62	(20)	390	13
14	Allocated from NuCare Services	2009	20,056	1,313	20	1,003	(310)	5,625	14
15	Allocated from NuCare Services	2010	3,082	202	20	154	(48)	695	15
16	Allocated from NuCare Services	2011	167	11	20	8	(3)	33	16
17	Allocated from NuCare Services	2012	185	12	20	9	(3)	26	17
18	Allocated from NuCare Services	2014	2,318	152	20	70	(82)	70	18
19									19
20	Allocated from 7257 N. Lincoln Ave.	2005	5,437	38	20	344	306	3,253	20
21	Allocated from 7257 N. Lincoln Ave.	2004	1,185		20	59	59	622	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)		$ 110,798	$ 4,482		$ 4,288	$ (194)	$ 38,881	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 110,798	$ 4,482		$ 4,288	$ (194)	$ 38,881	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)		$ 110,798	$ 4,482		$ 4,288	$ (194)	$ 38,881	34

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,862,215	$ 44,593	$ 202,560	$ 157,967	10	$ 343,251	71
72	Current Year Purchases	29,473	602	2,794	2,192	10	2,794	72
73	Fully Depreciated Assets	1,743,644		70	70	10	1,743,642	73
74								74
75	TOTALS	$ 3,635,331	$ 45,195	$ 205,424	$ 160,229		$ 2,089,687	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 Services (	2014	$ 548	$ 36	$ 110	$ 74	5	$ 484	76
77										77
78										78
79										79
80	TOTALS			$ 548	$ 36	$ 110	$ 74		$ 484	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,504,548	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 478,649	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 543,739	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,090	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,375,791	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.

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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				5,200			5
6	Allocated from NuCare Services Corp				420			6
7	TOTAL				$ 5,620 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 47,618 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 NuCare Services Corp		$	$ 2,582	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,582	21

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

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 1,017,766	$		$ 1,017,766	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			308,692			308,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			924,239			924,239	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				586,413		586,413	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					31,152	172,352		203,504	13
14	TOTAL			$		$ 2,281,849	$ 758,765		$ 3,040,614	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.

STATE OF ILLINOIS

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,500	$ 257,760	1
2	Cash-Patient Deposits	7,053	7,053	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,672,878	6,515,509	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,837	21,521	6
7	Other Prepaid Expenses	6,215	6,215	7
8	Accounts Receivable (owners or related parties)	4,791,792	6,180,845	8
9	Other(specify):	21,392	280,043	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,508,667	$ 13,268,946	10
	B. Long-Term Assets			
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	883,137	1,707,544	15
16	Equipment, at Historical Cost	947,173	2,319,401	16
17	Accumulated Depreciation (book methods)	(1,368,120)	(6,578,796)	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):		487,653	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 462,190	$ 6,841,169	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,970,857	$ 20,110,115	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,345,214	$ 3,345,213	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,718	36,718	28
29	Short-Term Notes Payable	3,484,686	3,621,677	29
30	Accrued Salaries Payable	553,176	553,176	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,935	63,935	31
32	Accrued Real Estate Taxes(Sch.IX-B)		446,150	32
33	Accrued Interest Payable		22,206	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	512,090	512,090	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,995,819	$ 8,601,165	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,212,961	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,212,961	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,995,819	$ 17,814,126	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,975,038	$ 2,295,989	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,970,857	$ 20,110,115	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,966,187	1	
2	Restatements (describe):		2	
3	**Prior Period Rent**	(685,482)	3	
4	**Prior Period Workers Compensation**	4,595	4	
5	**Rounding**	4	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,285,304	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	689,734	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 689,734	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,975,038	24	*

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

Facility Name & ID Number The Renaissance at 87th St # 0042093 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,903,540	1
2	Discounts and Allowances for all Levels	(3,351,070)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,552,470	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,582,434	6
7	Oxygen	22,485	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,604,919	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,268,837	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	386,664	19
20	Radiology and X-Ray	86,953	20
21	Other Medical Services	142,637	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,885,091	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***	39,429	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 39,439	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	77,716	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,716	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,159,635	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,904,117	31
32	Health Care	5,912,103	32
33	General Administration	4,768,918	33
	B. Capital Expense		
34	Ownership	2,188,566	34
	C. Ancillary Expense		
35	Special Cost Centers	3,236,361	35
36	Provider Participation Fee	459,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,469,901	40
41	**Income before Income Taxes (line 30 minus line 40)****	689,734	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 689,734	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,761,315	44
45	Private Pay - Net Inpatient Revenue	544,408	45
46	Medicare - Net Inpatient Revenue	1,445,424	46
47	Other-(specify) CCHHS	(925)	47
48	Other-(specify) Managed Care, Hospice	802,248	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,552,470	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,979	2,210	$ 117,117	$ 52.99	1
2	Assistant Director of Nursing	1,928	2,094	92,985	44.41	2
3	Registered Nurses	39,004	42,010	1,385,607	32.98	3
4	Licensed Practical Nurses	55,332	59,566	1,629,726	27.36	4
5	CNAs & Orderlies	118,503	128,313	1,412,723	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,463	6,107	170,088	27.85	8
9	Activity Director	4,310	4,796	92,044	19.19	9
10	Activity Assistants	7,138	8,155	88,886	10.90	10
11	Social Service Workers	7,929	8,702	209,362	24.06	11
12	Dietician	2,114	2,371	33,317	14.05	12
13	Food Service Supervisor	1,989	2,174	56,654	26.06	13
14	Head Cook	6,132	6,733	82,446	12.25	14
15	Cook Helpers/Assistants	18,598	20,840	189,440	9.09	15
16	Dishwashers					16
17	Maintenance Workers	4,566	4,904	108,270	22.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,607	2,717	145,636	53.60	20
21	Assistant Administrator					21
22	Other Administrative	481	481	46,779	97.25	22
23	Office Manager	3,318	3,549	65,462	18.45	23
24	Clerical	12,984	13,949	264,481	18.96	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	1,965	2,277	32,198	14.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,582	9,882	238,756	24.16	33
34	TOTAL (lines 1 - 33)	305,922	331,830	$ 6,461,977 *	$ 19.47	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	360	$ 17,020	01-03	35
36	Medical Director	Monthly	6,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	37	2,012	10-03	38
39	Pharmacist Consultant	Monthly	16,444	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	32	1,760	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Medical Consultant	Monthly	72,720	10 - 03	47
48					48
49	TOTAL (lines 35 - 48)	429	$ 116,706		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daniel L. Johnson	Administrator	0.00%	$ 127,482
Corey M. David	Administrator	0.00%	18,154
Marilyn Flaherty	VP Medicare Reimb	0.00%	8,791
Sondra Mixdorf	VP Clinical	0.00%	13,109
Tony Prather	Regional Director	0.00%	24,879
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 192,416

B. Administrative - Other

Description	Amount
NuCare Services Corp - Bookkeeping Services	$ 1,153,654
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,153,654
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, Rothblatt	Accounting	$ 26,843
McGladrey, LLP	Accounting	581
Ability Network Inc.	Computer Services	2,746
Creative Technology Solutions	Computer Services	14,839
Emdeon	Computer Services	1,153
E-Health Data Solutions	Computer Services	5,112
Formation Healthcare Group	Computer Services	1,005
HDSI Health Data System	Computer Services	5,482
KIPP Computer Solutions	Computer Services	100
Market Metrix of Delaware	Computer Services	2,278
MDI Achieve	Computer Services	22,658
See Supplemental Schedule		118,555
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 201,353

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 238,869
Unemployment Compensation Insurance	193,854
FICA Taxes	492,606
Employee Health Insurance	279,519
Employee Meals	31,116
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	466
Vision Insurance	127
401K Match	3,103
Other Employee Benefits	4,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,244,260

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	509
Health Care Worker Background Check	13,915
(Indicate # of checks performed 1234)	
Patient Background Checks	
Dues ansd Subscriptions	18,158
License and Permits	20,141
Advertising and Promotions	48,758
Allocated from NuCare Services Corp	1,422
Less: Public Relations Expense	( )
Non-allowable advertising	(48,758)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,620
Allocated from NuCare Services Corp	1,218
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,838

**See instructions.

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

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

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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 $8,808 and Alliance $1,110**

(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. $ **1,922** 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. $ **459,836**
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. $ **31,116** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.