FOR BHF USE

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

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.

I. IDPH License ID Number: 0042085

Facility Name: The Renaissance at Sth Shore

Address: 2425 E 71st Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 721-5000 **Fax #** (773) 721-6850

HFS ID Number:

Date of Initial License for Current Owners: 10/23/1998

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 Sth Shore # 0042085 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	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			19,892	19,892	8
9	SNF/PED					9
10	ICF	57,351	2,605	1,412	61,368	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,351	2,605	21,304	81,260	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.77%

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 10/23/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/23/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 248 and days of care provided 17,196

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	446,315	112,782	15,892	574,989		574,989		574,989			1
2	Food Purchase		403,701		403,701	(22,776)	380,925	(129)	380,796			2
3	Housekeeping	282,318	64,939		347,257		347,257		347,257			3
4	Laundry	170,614	41,940		212,554		212,554		212,554			4
5	Heat and Other Utilities			312,913	312,913		312,913	(5,930)	306,983			5
6	Maintenance	107,659	133,536	286,400	527,595		527,595	24,238	551,833			6
7	Other (specify):*							468	468			7
8	TOTAL General Services	1,006,906	756,898	615,205	2,379,009	(22,776)	2,356,233	18,646	2,374,879			8
	B. Health Care and Programs											
9	Medical Director			61,227	61,227		61,227		61,227			9
10	Nursing and Medical Records	5,731,430	815,022	15,950	6,562,402		6,562,402	(12,764)	6,549,638			10
10a	Therapy	178,604			178,604		178,604		178,604			10a
11	Activities	247,383	21,274	1,980	270,637		270,637		270,637			11
12	Social Services	202,773			202,773		202,773		202,773			12
13	CNA Training											13
14	Program Transportation			6,104	6,104		6,104	(720)	5,384			14
15	Other (specify):*							1,950	1,950			15
16	TOTAL Health Care and Programs	6,360,190	836,296	85,261	7,281,747		7,281,747	(11,534)	7,270,213			16
	C. General Administration											
17	Administrative	239,378		1,206,172	1,445,550		1,445,550	(1,161,708)	283,842			17
18	Directors Fees											18
19	Professional Services			112,605	112,605	(14,746)	97,859	83,815	181,675			19
20	Dues, Fees, Subscriptions & Promotions			85,081	85,081		85,081	(58,156)	26,925			20
21	Clerical & General Office Expenses	274,233	67,733	864,212	1,206,178		1,206,178	(513,919)	692,259			21
22	Employee Benefits & Payroll Taxes			1,448,564	1,448,564	22,776	1,471,340		1,471,340			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,353	6,353		6,353	(95)	6,258			24
25	Other Admin. Staff Transportation			279	279		279	6,508	6,787			25
26	Insurance-Prop.Liab.Malpractice			1,180,540	1,180,540		1,180,540	(133,019)	1,047,521			26
27	Other (specify):*							24,385	24,385			27
28	TOTAL General Administration	513,611	67,733	4,903,806	5,485,150	8,030	5,493,180	(1,752,188)	3,740,992			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,880,707	1,660,927	5,604,272	15,145,906	(14,746)	15,131,160	(1,745,076)	13,386,084			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 Sth Shore #0042085 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			288,069	288,069		288,069	1,231	289,300			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,018	82,018		82,018	60	82,078			32
33	Real Estate Taxes			444,516	444,516	14,746	459,262	4,371	463,633			33
34	Rent-Facility & Grounds			1,405,332	1,405,332		1,405,332	496	1,405,828			34
35	Rent-Equipment & Vehicles			57,820	57,820		57,820	3,049	60,869			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,277,755	2,277,755	14,746	2,292,501	9,208	2,301,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		837,634	2,052,582	2,890,216		2,890,216	(46,667)	2,843,549			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			517,975	517,975		517,975		517,975			42
43	Other (specify):*	308,707			308,707		308,707	(308,707)	0			43
44	**TOTAL Special Cost Centers**	308,707	837,634	2,570,557	3,716,898		3,716,898	(355,374)	3,361,524			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,189,414	2,498,561	10,452,584	21,140,559		21,140,559	(2,091,242)	19,049,317			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 Sth Shore # 0042085 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	(9,187)	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	(9,741)	30		9
10	Interest and Other Investment Income	(2,594)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,599)	21		18
19	Entertainment	(1,533)	24		19
20	Contributions	(20,047)	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	(540,425)	21		24
25	Fund Raising, Advertising and Promotional	(38,119)	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	(625,235)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,248,609)		$	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)	(842,633)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (842,633)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,091,242)		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

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The Renaissance at Sth Shore

ID# 0042085

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Record Copies	$ (734)	21	1
2	Jury Duty Income	(430)	10	2
3	Patient Needs	(16,298)	10	3
4				4
5	Community Related Wages	(34,414)	43	5
6	Guest Related Wages	(80,764)	43	6
7	Bank Charges	(15,389)	21	7
8	Sequestration Fee	(189,852)	21	8
9	Insurance - Prior Year	(133,761)	26	9
10	Transportation Reimbursement	(720)	14	10
11	Annual Reports	(200)	20	11
12	Collection Expense	(17,529)	21	12
13	Non-Allowable Fees	(7,434)	21	13
14	2013 Accrual Reversal	107,000	19	14
15	COPE Dues	(1,470)	20	15
16	Non-Allowable Legal	(33,692)	19	16
17	Capitalized R&M	(11,752)	06	17
18	Additional R&M	20,600	06	18
19	Marketing Salaries	(193,529)	43	19
20	Prior Year - Consultants Reimbursement	(14,868)	10	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(625,235)		49

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The Renaissance at Sth Shore

ID# 0042085

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 Sth Shore **#** 0042085 **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	(129)											(129)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,187)		3,257									(5,930)	5
6	Maintenance	8,848		15,390									24,238	6
7	Other (specify):*			468									468	7
8	**TOTAL General Services**	(468)		19,114									18,646	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,596)		22,012				(3,180)					(12,764)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(720)											(720)	14
15	Other (specify):*			1,950									1,950	15
16	**TOTAL Health Care and Programs**	(32,316)		23,961				(3,180)					(11,534)	16
	C. General Administration													
17	Administrative			(1,174,208)			12,500						(1,161,708)	17
18	Directors Fees													18
19	Professional Services	73,308		9,882			625						83,815	19
20	Fees, Subscriptions & Promotions	(59,836)		1,680									(58,156)	20
21	Clerical & General Office Expenses	(772,962)		254,690			4,354						(513,919)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,533)		1,438									(95)	24
25	Other Admin. Staff Transportation			6,508									6,508	25
26	Insurance-Prop.Liab.Malpractice	(133,761)		742									(133,019)	26
27	Other (specify):*			22,896			1,489						24,385	27
28	**TOTAL General Administration**	(894,784)		(876,372)			18,968						(1,752,188)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(927,568)		(833,297)			18,968	(3,180)					(1,745,076)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Renaissance at Sth Shore **#** 0042085 **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	(9,741)		10,972									1,231	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,594)		2,654									60	32
33	Real Estate Taxes			4,371									4,371	33
34	Rent-Facility & Grounds			496									496	34
35	Rent-Equipment & Vehicles			3,049									3,049	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(12,335)		21,543									9,208	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(28,627)	(6,889)		(11,151)					(46,667)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(308,707)											(308,707)	43
44	**TOTAL Special Cost Centers**	(308,707)			(28,627)	(6,889)		(11,151)					(355,374)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,248,609)		(811,754)	(28,627)	(6,889)	18,968	(14,331)					(2,091,242)	45

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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%	$ 3,257	$ 3,257	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	5,279	5,279	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	10,111	10,111	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	468	468	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	22,012	22,012	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,950	1,950	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	31,964	31,964	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	9,882	9,882	22
23	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,680	1,680	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	214,538	214,538	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	40,151	40,151	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,438	1,438	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	6,508	6,508	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	742	742	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	22,896	22,896	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	10,972	10,972	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,654	2,654	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	4,371	4,371	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	496	496	33
34	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	3,049	3,049	34
35	V								35
36	V	17	BOOKKEEPING FEES	1,206,172	NUCARE SERVICES CORP.	100.00%		(1,206,172)	36
37	V								37
38	V								38
39	Total			$ 1,206,172			$ 394,418	$ * (811,754)	39

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	$ 309,993	INTEGRA HEALTHCARE EQUIPMENT		$ 281,366	$ (28,627)	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			$ 309,993			$ 281,366	$ * (28,627)	39

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	$ 33,050	INTEGRA RESPIRATORY SERVICES LLC		$ 26,161	$ (6,889)	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			$ 33,050			$ 26,161	$ * (6,889)	39

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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	$ 13,700	Lifeline Ambulance	100.00%	$ 10,520	$ (3,180)	15
16	V	39	Ambulance	48,029	Lifeline Ambulance	100.00%	36,878	(11,151)	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			$ 61,729			$ 47,398	$ * (14,331)	39

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	$ 178,583	MAPLE LEAF		$ 178,583	$	15
16	V	26	Liability Insurance	577,228	MAPLE LEAF		577,228		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			$ 755,811			$ 755,811	$ *	39

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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 Sth Shore # 0042085 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 Sth Shore # 0042085 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	4.84%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REI	CHICAGO	JLR FINANCIAL SERVICES COI	LINCOLNWOOD	FINANCIAL	1
2	JONATHAN BRYAN STERN TRUST 2001	0.89%	CALIFORNIA GARDENS CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	2
3	MARSHALL A. MAUER	6.17%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	3
4	MAURICE I. AARON	4.69%	CLARIDGE IMPERIAL, LTD.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5	ORIOLE TRUST	4.89%	JACKSON CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKKEEPING	5
6	RAJCHENBACH FAMILY TRUST	24.70%	MONROE CORP.	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	6
7	ROBERT HARTMAN FAMILY TRUST	21.02%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	INTEGRA HEALTHCARE EQUI	ELMHURST	DME & MEDICAL SUPPLIES	7
8	SUSAN L. STERN	4.84%	ARIA POST ACUTE CARE	HILLSIDE	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	8
9	TODD ANDREW STERN TRUST 2001	0.89%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	MAPLELEAF INSURANCE	GRAND CAYMAN	LIABILITY INS	9
10	MARK HOLLANDER DISCRETIONARY TRUST	8.23%	RENAISSANCE EAST	MESA, ARIZONA	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY	10
11	SHARON HOLLANDER DISCRETIONARY TRUST	8.23%	RENAISSANCE PARK SOUTH, LLC	CHICAGO				11
12	FEIGE C. KNOBEL DISCRETIONARY TRUST	8.23%	RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13	JONATHAN AARON	1.48%	RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14	EVAN MICHAEL STERN 2005 TRUST	0.89%	RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT-HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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	See Attached	6	10.00%	Alloc. Salary	$ 12,500	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 12,500		13

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

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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	$	90,520	$ 3,257	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	72,310	72,310	90,520	5,279	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,239,904	17	138,492		90,520	10,111	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,239,904	17	6,405		90,520	468	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	301,506	301,506	90,520	22,012	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS	1,239,904	17	26,708		90,520	1,950	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	437,828	437,828	90,520	31,964	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,239,904	17	135,365		90,520	9,882	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,239,904	17	23,010		90,520	1,680	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,239,904	17	2,938,655	2,938,655	90,520	214,538	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,239,904	17	549,976		90,520	40,151	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,239,904	17	19,695		90,520	1,438	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,239,904	17	89,139		90,520	6,508	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,239,904	17	10,164		90,520	742	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,239,904	17	313,624		90,520	22,896	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,239,904	17	150,292		90,520	10,972	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,239,904	17	36,349		90,520	2,654	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,239,904	17	59,877		90,520	4,371	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,239,904	17	6,796		90,520	496	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,239,904	17	41,766		90,520	3,049	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,402,565	$ 3,750,299		$ 394,418	25

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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			$	$		$ 281,366	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					$	$		$ 281,366	25

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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			$	$		$ 26,161	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 26,161	25

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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 Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 9499262

	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			$	$		$ 10,520	1
2	39	Ambulance	Direct Allocation						36,878	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					$	$		$ 47,398	25

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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				$	$		$ 577,228	1
2	26	Libility Insurance								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					$	$		$ 577,228	25

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 Sth Shore # 0042085 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 Sth Shore # 0042085 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 Sth Shore # 0042085 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				2,400,000			82,018	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,400,000			$ 82,018	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,594)	10
11	Alloc from Nucare		X								2,654	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 60	14
15	TOTALS (line 9+line14)						$	$ 2,400,000			$ 82,078	15

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

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

**** 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 Sth Shore # 0042085 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 Sth Shore **#** 0042085 **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.**	$ 545,318	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.)		$ 487,217	2
3. Under or (over) accrual (line 2 minus line 1).		$ (58,101)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 506,988	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.)**		$ 14,746	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 $ For 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.		$ 463,633	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	406,100	8
	2010	507,745	9
	2011	490,252	10
	2012	534,626	11
	2013	482,846	12

2013 Accrual = $482,846 x 1.05 = $506,988

Allocated from Nucare $4,371

	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 Sth Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.	21-30-101-003-0000	Long Term Care Property	$ 37,556.40	$ 37,556.40
2.	21-30-101-004-0000	Long Term Care Property	$ 70,558.63	$ 70,558.63
3.	21-30-101-014-0000	Long Term Care Property	$ 192,040.73	$ 192,040.73
4.	21-30-101-022-0000	Long Term Care Property	$ 52,885.85	$ 52,885.85
5.	21-30-101-023-0000	Long Term Care Property	$ 129,804.25	$ 129,804.25
6.	See Attached	Home Office Allocation	$ 89,368.57	$ 4,371.36
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 572,214.43	$ 487,217.22

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 Sth Shore COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Sth Shore # 0042085 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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	Alloc from 7257 N. Lincoln		2004	$ 7,826	1
2					2
3	TOTALS			$ 7,826	3

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	78,106		20	3,905	3,905	63,096	9
10	Various			1999	88,720		20	4,436	4,436	69,331	10
11	Various			2000	72,602		20	3,630	3,630	53,240	11
12	Various			2001	45,629		20	2,281	2,281	31,111	12
13	Various			2002	11,757		20			11,757	13
14	Various			2003	16,299		20			16,299	14
15	Various			2004	62,649		20	3,376	3,376	62,649	15
16	Various			2005	10,333		20	647	647	8,371	16
17	Various			2006	72,736		20	3,549	3,549	59,377	17
18	Various			2007	176,978		20	17,586	17,586	135,023	18
19	Various			2008	131,853		20	11,460	11,460	72,196	19
20	Various			2009	441,303		20	43,082	43,082	241,677	20
21	Various			2010	174,612		20	20,967	20,967	101,056	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 Sth Shore # 0042085 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)								67
68	Related Party Allocations (Pages 12H & 12I)		130,847	5,291		5,066	(225)	45,916	68
69	Financial Statement Depreciation			288,072			(288,072)		69
70	TOTAL (lines 4 thru 69)		$ 1,514,422	$ 293,363		$ 119,986	$ (173,377)	$ 971,099	70

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$ 1,514,422	$ 293,363		$ 119,986	$ (173,377)	$ 971,099	1
2	300 Ft 5 1/2 Ft Hand Rail Honduras Mahogany, 58 Pcs End Cap, 2	2011	7,591		20	380	380	1,518	2
3	Electrical Work For Crd Access Expansion	2011	5,700		20	570	570	2,280	3
4	Painting Of 32 Resident Rooms Walls, Bathrooms, Therapy Rm, S	2011	18,085		20	1,808	1,808	6,932	4
5	Removal Of Nurses Station - 50% Deposit	2011	7,710		20	771	771	2,956	5
6	Fabricate And Install Cabinets In 4 Shower Rooms 50% Deposit	2011	5,852		20	585	585	2,195	6
7	50% Balance, Awnings Around Facility, 1 Patio Awning, 1 Back D	2011	8,150		20	815	815	3,056	7
8	Furnish And Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	5,386		20	539	539	2,020	8
9	Labor To Install 1 Hydraulic Oil Cooler On Passenger Elevator	2011	4,486		20	449	449	1,682	9
10	Replace Corridor Lay In Lighting W/ Corelite T5 On 2Nd, 3Rd An	2011	14,575		20	1,458	1,458	5,344	10
11	Expansion Remodeling Of 2Nd, 3Rd And 4Th Flr Dining Rooms, 9	2011	48,300		20	4,830	4,830	17,710	11
12	Furnish And Install 6 Oak Doors, 2 Drawers And Drwr Fronts In N	2011	6,884		20	344	344	1,262	12
13	Balance Due - Expansion Remodeling Of 2Nd, 3Rd And 4Th Flr Di	2011	11,491		20	1,149	1,149	4,118	13
14	Fabricate And Install One New Flex Sign Face To Replace Existing	2011	13,625		20	908	908	3,255	14
15	Replace 20 Lights, 1St Flr Corridor, 4Th Flr, 29 Wall Sconce Light	2011	10,265		20	1,027	1,027	3,593	15
16	Installation Of Cabinetry And Mouldings - 50% Deposit	2011	8,294		20	829	829	3,110	16
17	3Rd Flr Bathroom Remodeling. Remove Tiles From Wall, Replace	2011	6,050		20	605	605	1,865	17
18	Shower Rooms Project- Daltiles, Waterproof Membranes, Ceramic	2011	17,407		20	1,741	1,741	5,657	18
19	Uninstall Various Electrical Wiring Piping Junction Boxes And To	2011	3,125		20	313	313	1,146	19
20	50% Deposit-Awnings Around Facility 4 Flrs 200Ft X 3Ft X 2Ft;Pa	2011	8,150		20	815	815	2,785	20
21	Bathroom Flooring - Ceramic	2012	6,700		20	447	447	1,340	21
22	Polar Rails In Rooms	2012	2,697		20	135	135	382	22
23	First Floor Bathroom - Ceramic Flooring	2012	7,750		20	517	517	1,464	23
24	Second Floor Bathroom - Ceramic Flooring	2012	5,500		20	367	367	978	24
25	Replace Boiler Pump, Switch, Gauge	2012	3,320		20	277	277	784	25
26	Bathroom Drywall	2012	2,600		20	260	260	650	26
27	Guard System - Security	2012	2,517		20	503	503	1,133	27
28	Belts, Heater Hose, Governor Controller, And Actuator	2012	5,409		20	541	541	1,217	28
29	Elevator Repairs	2012	2,800		20	280	280	630	29
30	Security System-Replace Dvr,Cameras,Cctv On Parking Lot & Str	2013	4,878		20	976	976	1,626	30
31	Awning	2013	6,380		20	638	638	1,010	31
32	Entrance & Ramp Of Parking Garage	2013	32,575		20	2,172	2,172	3,438	32
33	Wiring For Wi-Fi	2013	7,388		20	1,478	1,478	2,586	33
34	TOTAL (lines 1 thru 33)		$ 1,816,062	$ 293,363		$ 148,509	$ (144,854)	$ 1,060,821	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$ 1,816,062	$ 293,363		$ 148,509	$ (144,854)	$ 1,060,821	1
2	8 Cctvs	2013	4,220		20	844	844	1,266	2
3	Divider Wall, Cabinet-Room 339, Window Sills-All Resident Room	2013	16,680		20	3,336	3,336	4,170	3
4	Install 2 Cctv Outside Facing Parking Lot	2013	3,310		20	331	331	414	4
5	Sprinkler System	2013	9,422		20	942	942	1,178	5
6	Hvac Motors & Blowers	2013	4,813		20	963	963	1,845	6
7	1St - 4Th Floors - Flooring, Light Fixtures, Paint, Cabinetry, Wallc	2013	616,651		20	30,833	30,833	48,818	7
8	Elevator Repairs & 16 Led Recessed Cans	2013	5,480		20	274	274	297	8
9	Replace Lighting Balast Parking Lot Top & Mounted On Bldg, Re	2013	6,660		20	333	333	666	9
10	Boiler Repairs - 4 Ignitors And 2 Boards	2013	6,957		20	348	348	667	10
11	Window Replacement For Foom 208 And Window For Attic Stock	2013	2,716		20	136	136	249	11
12	Replaced Roof Outside Oxygen Room	2013	3,920		20	196	196	310	12
13	Labor & Material To Service And Replace Siemens Elevator Lines	2013	2,718		20	136	136	147	13
14	A/C Repair	2013	3,243		20	162	162	270	14
15	Tiling - Therapy Room	2013	3,302		20	165	165	179	15
16	Corner Guards For Entire 1St, 2Nd, 4Th & Part Of 3Rd Floor	2013	3,564		20	178	178	208	16
17	Lower Level Therapy Gym Countertop & Workstation	2014			20				17
18	Brackets, Window Sills In Bistro & Dining Room	2014	5,610		20	373	373	373	18
19	Cabinets & Studs, Ultralight Dry Wall For Therapy Room	2014	2,970		20	272	272	272	19
20	Electrical Work - Therapy Room	2014	9,800		20	898	898	898	20
21	Signs & Banners For Entire 1St Floor	2014	2,554		20	149	149	149	21
22	1St Fl Improv-Entire Floor Covering, Door Reface & Window	2014			20				22
23	Treatement In Resident Rooms, Surface Top In Dinnig Room	2014	139,380		20	8,131	8,131	8,131	23
24	5 Wanderguard Complete System	2014	14,754		20	984	984	984	24
25	1 Fire Alarm System Device, 1 Replaced Tamper Panel Trouble Be	2014	7,755		20	194	194	194	25
26	Electrical Work In Parking Lot, Install New Cameras In The Park	2014	6,020		20	50	50	50	26
27	Install 10 New Secutiry Cameras.	2014	5,170		20	345	345	345	27
28	Pump Repair & Replace Motor For Water Heater	2014	2,818		20	141	141	141	28
29	Repair Pipe In Dietary Area	2014	2,850		20	143	143	143	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,709,398	$ 293,363		$ 199,365	$ (93,998)	$ 1,133,184	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$ 2,709,398	$ 293,363		$ 199,365	$ (93,998)	$ 1,133,184	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,709,398	$ 293,363		$ 199,365	$ (93,998)	$ 1,133,184	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$ 2,709,398	$ 293,363		$ 199,365	$ (93,998)	$ 1,133,184	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,709,398	$ 293,363		$ 199,365	$ (93,998)	$ 1,133,184	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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									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)		$	$		$	$	$	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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 NuCare 7257 N. Lincoln Ave	2004	70,436	1,806	20	2,012	206	22,389	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from NuCare Services	2003	855	56	20	43	(13)	475	9
10	Allocated from NuCare Services	2004	17,361	1,136	20	869	(267)	9,309	10
11	Allocated from NuCare Services	2005	1,029	67	20	52	(15)	507	11
12	Allocated from NuCare Services	2006	1,396	91	20	70	(21)	584	12
13	Allocated from NuCare Services	2008	1,471	96	20	74	(22)	460	13
14	Allocated from NuCare Services	2009	23,685	1,550	20	1,184	(366)	6,643	14
15	Allocated from NuCare Services	2010	3,640	238	20	182	(56)	820	15
16	Allocated from NuCare Services	2011	197	13	20	10	(3)	39	16
17	Allocated from NuCare Services	2012	219	14	20	11	(3)	30	17
18	Allocated from NuCare Services	2014	2,737	179	20	83	(96)	83	18
19									19
20	Allocated from NuCare 7257 N. Lincoln Ave	2005	6,421	45	20	406	361	3,842	20
21	Allocated from NuCare 7257 N. Lincoln Ave	2004	1,400		20	70	70	735	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)		$ 130,847	$ 5,291		$ 5,066	$ (225)	$ 45,916	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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		$ 130,847	$ 5,291		$ 5,066	$ (225)	$ 45,916	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 130,847	$ 5,291		$ 5,066	$ (225)	$ 45,916	34

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	$ 750,106	$ 4,926	$ 83,515	$ 78,589	10	$ 567,669	71
72	Current Year Purchases	59,205	710	6,208	5,498	10	6,208	72
73	Fully Depreciated Assets	574,837		83	83	10	574,835	73
74								74
75	TOTALS	$ 1,384,148	$ 5,636	$ 89,806	$ 84,170		$ 1,148,712	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	2014	$ 647	$ 42	$ 129	$ 87	5	$ 571	76
77										77
78										78
79										79
80	TOTALS			$ 647	$ 42	$ 129	$ 87		$ 571	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)	$ 4,102,019	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 299,041	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 289,300	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,741)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,282,467	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 Sth Shore # 0042085 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: South Shore Partnership
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1998	248		$ 1,403,907			3
4	Additions							4
5	Storage				1,425			5
6	Allocated from NuCare				496			6
7	TOTAL		248		$ 1,405,828 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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: $ 57,820 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		$	$ 3,049	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,049	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 Sth Shore # 0042085 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 Sth Shore # 0042085 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	$		$ 865,073	$		$ 865,073	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			225,980			225,980	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			936,962			936,962	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				575,243		575,243	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					24,567	262,391		286,958	13
14	TOTAL			$		$ 2,052,582	$ 837,634		$ 2,890,216	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 Sth Shore # 0042085 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	$ 8,634	$	1
2	Cash-Patient Deposits	18,996		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,643,002		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,365		6
7	Other Prepaid Expenses	40,980		7
8	Accounts Receivable (owners or related parties)	1,213,218		8
9	Other(specify):	2,401,844		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,337,039	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,813,107		15
16	Equipment, at Historical Cost	1,341,084		16
17	Accumulated Depreciation (book methods)	(2,827,612)		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):	27,930		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,354,509	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,691,548	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,367,322	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,152		28
29	Short-Term Notes Payable	2,400,000		29
30	Accrued Salaries Payable	681,525		30
31	Accrued Taxes Payable (excluding real estate taxes)	85,342		31
32	Accrued Real Estate Taxes(Sch.IX-B)	506,988		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	805,039		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,859,368	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,859,368	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,832,180	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,691,548	$	48

***(See instructions.)**

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,834,198	1
2	Restatements (describe):		2
3	**Workers' Comp Insurance**	74,710	3
4	**Straight -Line Rent**	(50,651)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,858,257	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	498,373	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	475,550	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)**	$ 973,923	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)**	$ 2,832,180	24 *

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

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 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	$ 16,227,483	1
2	Discounts and Allowances for all Levels	(2,200,187)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,027,296	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,897,755	6
7	Oxygen	27,975	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,925,730	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	1,129,441	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	245,951	19
20	Radiology and X-Ray	79,406	20
21	Other Medical Services	211,752	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,666,550	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***	2,594	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,604	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	16,752	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,752	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,638,932	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,379,009	31
32	Health Care	7,281,747	32
33	General Administration	5,485,150	33
	B. Capital Expense		
34	Ownership	2,277,755	34
	C. Ancillary Expense		
35	Special Cost Centers	3,198,923	35
36	Provider Participation Fee	517,975	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,140,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	498,373	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 498,373	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,895,334	44
45	Private Pay - Net Inpatient Revenue	525,573	45
46	Medicare - Net Inpatient Revenue	3,445,547	46
47	Other-(specify) CCHHS	44,134	47
48	Other-(specify) Managed Care, Hospice	116,708	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,027,296	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.**

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2,037	2,086	$ 128,837	$ 61.76	1
2	Assistant Director of Nursing	1,945	2,014	80,955	40.20	2
3	Registered Nurses	42,009	45,049	1,483,906	32.94	3
4	Licensed Practical Nurses	73,634	77,744	2,078,649	26.74	4
5	CNAs & Orderlies	158,320	172,070	1,845,603	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,060	14,484	178,604	12.33	8
9	Activity Director	3,649	3,877	89,173	23.00	9
10	Activity Assistants	12,409	13,761	158,210	11.50	10
11	Social Service Workers	7,484	8,079	202,773	25.10	11
12	Dietician					12
13	Food Service Supervisor	5,340	6,419	124,846	19.45	13
14	Head Cook	5,860	6,271	76,177	12.15	14
15	Cook Helpers/Assistants	21,900	23,912	245,292	10.26	15
16	Dishwashers					16
17	Maintenance Workers	4,313	4,685	107,659	22.98	17
18	Housekeepers	24,319	26,413	282,318	10.69	18
19	Laundry	13,317	15,092	170,614	11.30	19
20	Administrator	1,853	2,096	151,777	72.41	20
21	Assistant Administrator	1,230	1,278	40,821	31.94	21
22	Other Administrative	481	481	46,780	97.26	22
23	Office Manager	1,562	1,685	39,950	23.71	23
24	Clerical	14,638	15,618	234,283	15.00	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	1,963	2,086	31,807	15.25	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	12,020	12,898	390,380	30.27	33
34	TOTAL (lines 1 - 33)	423,343	458,098	$ 8,189,414 *	$ 17.88	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	336	$ 15,892	01-03	35
36	Medical Director	Monthly	61,227	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,950	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	36	1,980	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	372	$ 95,049		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
Della Richardson	Administrator		$ 41,565
Rick Walworth	Administrator		110,212
Paven Rakalla	Assistant Admin		33,771
Laura A. Aranda	Assistant Admin		7,050
Marilyn Flaherty	Medicare Reimb		8,791
Sondra Mixdorf	VP Clinical		13,109
See Supplemental Schedule			24,879
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 239,378

B. Administrative - Other

Description	Amount
NuCare Services Corp - Bookkeeping Fees	$ 1,206,172
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,206,172

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 23,723
McGladrey	Accounting	686
Personnel Planners	Unemployment Consult	9,700
CDW Government	Computer Services	3,775
Creative Technology Solutions	Computer Services	18,441
EBS Master, LLC	Computer Services	1,153
E-Health Date Solutions	Computer Services	5,112
Formation HC Group	Computer Services	1,005
HDSI Health Data System	Computer Services	5,650
Macker TEK Limited	Computer Services	1,310
Market Matrix of Delaware	Computer Services	2,690
See Supplemental Schedule		39,360
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 112,605

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 246,109
Unemployment Compensation Insurance	305,822
FICA Taxes	587,896
Employee Health Insurance	293,645
Employee Meals	22,776
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	43,088
Dental Insurance	2,529
Other Employee Benefits	(33,335)
401K Expense	2,506
Vision Insurance	305
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,471,340

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,480
Advertising: Employee Recruitment	645
Health Care Worker Background Check	
(Indicate # of checks performed 370)	5,897
Patient Background Checks	
Dues & Subscirptions	4,616
Licenses & Inspections	11,607
Advertising & Promotion	38,119
Allocated from Nucare	1,680
Less: Public Relations Expense	( )
Non-allowable advertising	(38,119)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,925

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,820
Allocated from Nucare	1,438
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,258

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Renaissance at Sth Shore # 0042085 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Renaissance at Sth Shore **#** 0042085 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $4,455, Alliance of HC Council $1,205**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **none** Line

(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. $ **517,975**
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. $ **22,776** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) 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.