

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0042176

Facility Name: Renaissance at Hillside

Address: 4600 North Frontage Road Hillside 60162
 Number City Zip Code

County: Cook

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

HFS ID Number: 363980624001

Date of Initial License for Current Owners: 06/30/97

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 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) <u>Kimberley A. Waite, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 9/8/06

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>168</u>	Skilled (SNF)	<u>178</u>	<u>62,470</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>168</u>	TOTALS	<u>178</u>	<u>62,470</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>41,001</u>	<u>3,439</u>	<u>12,681</u>	<u>57,121</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,001</u>	<u>3,439</u>	<u>12,681</u>	<u>57,121</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

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)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 6/30/97

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

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 178 and days of care provided 10,656

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	309,091	77,988	20,919	407,998		407,998		407,998			1
2	Food Purchase		301,658		301,658		301,658	(181)	301,477			2
3	Housekeeping	296,298	51,066		347,364		347,364		347,364			3
4	Laundry		26,260		26,260		26,260		26,260			4
5	Heat and Other Utilities			211,844	211,844		211,844	(12,661)	199,183			5
6	Maintenance	56,844	53,457	113,182	223,483		223,483	3,396	226,879			6
7	Other (specify):*											7
8	TOTAL General Services	662,233	510,429	345,945	1,518,607		1,518,607	(9,446)	1,509,161			8
	B. Health Care and Programs											
9	Medical Director			32,232	32,232		32,232		32,232			9
10	Nursing and Medical Records	3,168,029	217,136	134,722	3,519,887		3,519,887		3,519,887			10
10a	Therapy	175,949		3,046	178,995		178,995		178,995			10a
11	Activities	166,735	24,083	3,265	194,083		194,083	(14,195)	179,888			11
12	Social Services	153,753		5,622	159,375		159,375		159,375			12
13	CNA Training											13
14	Program Transportation			4,995	4,995		4,995		4,995			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,664,466	241,219	183,882	4,089,567		4,089,567	(14,195)	4,075,372			16
	C. General Administration											
17	Administrative	184,845		586,162	771,007		771,007	(538,790)	232,217			17
18	Directors Fees											18
19	Professional Services			129,599	129,599		129,599	(45,230)	84,369			19
20	Dues, Fees, Subscriptions & Promotions			144,413	144,413		144,413	(74,289)	70,124			20
21	Clerical & General Office Expenses	166,093	52,191	357,844	576,128		576,128	(201,072)	375,056			21
22	Employee Benefits & Payroll Taxes			821,234	821,234		821,234	(27,656)	793,578			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,823	6,823		6,823	2,339	9,162			24
25	Other Admin. Staff Transportation			304	304		304	322	626			25
26	Insurance-Prop.Liab.Malpractice			262,781	262,781		262,781	1,186	263,967			26
27	Other (specify):*							26,874	26,874			27
28	TOTAL General Administration	350,938	52,191	2,309,160	2,712,289		2,712,289	(856,316)	1,855,973			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,677,637	803,839	2,838,987	8,320,463		8,320,463	(879,957)	7,440,506			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside #0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			167,566	167,566		167,566	15,728	183,294		30
31	Amortization of Pre-Op. & Org.			7,522	7,522		7,522		7,522		31
32	Interest			582,675	582,675		582,675	5,279	587,954		32
33	Real Estate Taxes			515,913	515,913		515,913	4,293	520,206		33
34	Rent-Facility & Grounds			1,214,495	1,214,495		1,214,495	383	1,214,878		34
35	Rent-Equipment & Vehicles			9,795	9,795		9,795	2,432	12,227		35
36	Other (specify):*										36
37	TOTAL Ownership			2,497,966	2,497,966		2,497,966	28,115	2,526,081		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		568,787	920,485	1,489,272		1,489,272		1,489,272		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			93,705	93,705		93,705		93,705		42
43	Other (specify):*	125,131		4,496	129,627		129,627	(129,627)			43
44	TOTAL Special Cost Centers	125,131	568,787	1,018,686	1,712,604		1,712,604	(129,627)	1,582,977		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,802,768	1,372,626	6,355,639	12,531,033		12,531,033	(981,469)	11,549,564		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(14,521)	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	5,584	30		9
10	Interest and Other Investment Income	(66)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(181)	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	(7,422)	21		18
19	Entertainment	(703)	21		19
20	Contributions	(18,380)	20		20
21	Owner or Key-Man Insurance	(27,656)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(158,234)	21		24
25	Fund Raising, Advertising and Promotional	(53,439)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,262)	20		28
29	Other-Attach Schedule	(361,232)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (637,512)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(343,957)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (343,957)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (981,469)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(181)											(181)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,521)		1,860									(12,661)	5
6	Maintenance			3,396									3,396	6
7	Other (specify):*													7
8	TOTAL General Services	(14,702)		5,256									(9,446)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(14,195)											(14,195)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(14,195)											(14,195)	16
	C. General Administration													
17	Administrative			(423,741)	(112,554)	(2,495)							(538,790)	17
18	Directors Fees													18
19	Professional Services	(50,805)		4,406	455	714							(45,230)	19
20	Fees, Subscriptions & Promotions	(75,674)		1,385									(74,289)	20
21	Clerical & General Office Expenses	(331,129)		128,079	1,038	940							(201,072)	21
22	Employee Benefits & Payroll Taxes	(27,656)											(27,656)	22
23	Inservice Training & Education													23
24	Travel and Seminar	760		1,575		4							2,339	24
25	Other Admin. Staff Transportation	(2)		324									322	25
26	Insurance-Prop.Liab.Malpractice			1,186									1,186	26
27	Other (specify):*			22,908	862	3,104							26,874	27
28	TOTAL General Administration	(484,506)		(263,878)	(110,199)	2,267							(856,316)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(513,403)		(258,622)	(110,199)	2,267							(879,957)	29

STATE OF ILLINOIS

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,584		10,144									15,728	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(66)		5,345									5,279	32
33	Real Estate Taxes			4,293									4,293	33
34	Rent-Facility & Grounds			383									383	34
35	Rent-Equipment & Vehicles			2,432									2,432	35
36	Other (specify):*													36
37	TOTAL Ownership	5,518		22,597									28,115	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(129,627)											(129,627)	43
44	TOTAL Special Cost Centers	(129,627)											(129,627)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(637,512)		(236,025)	(110,199)	2,267							(981,469)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$	There is no longer common ownership between the nursing home and the building company.		\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 1,860	1,860	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.		3,396	3,396	16
17	V	17 ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.		15,484	15,484	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.		4,406	4,406	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		1,385	1,385	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.		128,079	128,079	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		1,575	1,575	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		324	324	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.		1,186	1,186	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		20,416	20,416	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.		10,144	10,144	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.		5,345	5,345	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.		4,293	4,293	27
28	V	34 BUILDING RENT		NUCARE SERVICES CORP.		383	383	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.		2,432	2,432	29
30	V	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.		3,464	3,464	30
31	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.		6,373	6,373	31
32	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.				32
33	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		1,996	1,996	33
34	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		496	496	34
35	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.				35
36	V							36
37	V	17 MANAGEMENT FEES	449,062	NUCARE SERVICES CORP.			(449,062)	37
38	V							38
39	Total		\$ 449,062			\$ 213,037	\$ * (236,025)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 7,446	7,446	15
16	V	19 PROFESSIONAL FEES		JLR MANAGEMENT CORP.		455	455	16
17	V	21 OFFICE		JLR MANAGEMENT CORP.		1,038	1,038	17
18	V	27 PAYROLL TAXES		JLR MANAGEMENT CORP.		862	862	18
19	V							19
20	V	17 C. RAJCHENBACH-COMP.		JLR MANAGEMENT CORP.				20
21	V	27 PAYROLL TAXES		JLR MANAGEMENT CORP.				21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V	17 MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.			(120,000)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 120,000			\$ 9,801	\$ * (110,199)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 14,605	14,605	15
16	V	19 PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		714	714	16
17	V	21 CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		940	940	17
18	V	24 SEMINARS		CAREPATH HEALTH NETWORK		4	4	18
19	V	27 GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		3,104	3,104	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	17,100	CAREPATH HEALTH NETWORK			(17,100)	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		\$ 17,100			\$ 19,367	\$ * 2,267	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workmans Compensation	\$ 60,097	Diamond Insurance		\$ 60,097	\$	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			\$ 60,097			\$ 60,097	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	20.05%	See Attached	0.69	1.38%	Alloc-Nucare	\$ 3,464	17-7	1
2	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	5.00	7.69%	Alloc-JLR	7,445	17-7	2
3	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2.00	3.08%				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,909		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS 901,760	11	\$ 26,855	\$	62,470	\$ 1,860	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 901,760	11	49,026		62,470	3,396	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS 901,760	11	223,510	216,927	62,470	15,484	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 901,760	11	63,602		62,470	4,406	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 901,760	11	19,990		62,470	1,385	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 901,760	11	1,848,833	1,578,326	62,470	128,079	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 901,760	11	22,739		62,470	1,575	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 901,760	11	4,678		62,470	324	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 901,760	11	17,114		62,470	1,186	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 901,760	11	294,714		62,470	20,416	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 901,760	11	146,433		62,470	10,144	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 901,760	11	77,159		62,470	5,345	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 901,760	11	61,966		62,470	4,293	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS 901,760	11	5,526		62,470	383	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 901,760	11	35,109		62,470	2,432	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 10	11	50,000	50,000	1	3,464	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	11	92,000	92,000	3	6,373	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	70,000	70,000			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 10	11	28,814		1	1,996	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	11	7,164		3	496	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	3,060				21
22									22
23									23
24									24
25	TOTALS				\$ 3,148,292	\$ 2,007,253		\$ 213,037	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 81,900	\$ 81,900	5	\$ 7,446	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		5	455	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	11,414	11,414	5	1,038	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,486		5	862	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	60,037	60,037			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,770				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					\$ 172,607	\$ 153,351		\$ 9,801	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	CARE PATH FEES	302,112	9	\$ 258,032	\$ 258,032	17,100	\$ 14,605	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	302,112	9	12,615		17,100	714	2
3	21	CLERICAL AND GENERAL	CARE PATH FEES	302,112	9	16,607		17,100	940	3
4	24	SEMINARS	CARE PATH FEES	302,112	9	75		17,100	4	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	302,112	9	54,833		17,100	3,104	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					\$ 342,162	\$ 258,032		\$ 19,367	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation		\$	\$		\$ 60,097	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				\$	\$		\$ 60,097	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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	Shareholder Loan		X				\$	\$ 6,032,443			\$ 506,760	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
	Working Capital																
6	Sun Joint Venture		X								\$ 50,610	6					
7												7					
8	See Supplemental Schedule										\$ 25,305	8					
9	TOTAL Facility Related						\$	\$ 6,032,443			\$ 582,675	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13	See Supplemental Schedule										\$ 5,279	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 5,279	14					
15	TOTALS (line 9+line14)						\$	\$ 6,032,443			\$ 587,954	15					

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8	Hillside Ltd. Partnership		X				\$	\$			\$ 25,305	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15	Interest Income						\$	\$			\$ (66)	15								
16	Allocated - Nuicare Services										5,345	16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance at Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-17-101-017-0000</u>	<u>Long Term Care</u>	\$ <u>640,854.16</u>	\$ <u>499,866.24</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>94,936.32</u>	\$ <u>6,424.85</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>735,790.48</u>	\$ <u>506,291.09</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Renaissance at Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Renaissance at Hillside# 0042176 Report Period Beginning:01/01/06 Ending:12/31/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Hillside Assisted Living Center, Ltd - Assisted Living Center was closed in May 2005Hillside Montessori School - Child Day CareF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 37,608 2. Number of Years Over Which it is Being Amortized: 53. Current Period Amortization: 7,522 4. Dates Incurred: 2002

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated-7257 N. Lincoln</u>		<u>2004</u>	<u>\$ 10,828</u>	1
2					2
3	TOTALS			\$ 10,828	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			1997	12,990		20	650	650	6,081	9
10	Various			1998	40,341		20	2,017	2,017	17,198	10
11	Various			1999	52,100		20	2,606	2,606	19,788	11
12	Various			2000	30,099		20	2,181	2,181	27,459	12
13	Various			2001	49,889		20	2,496	2,496	14,109	13
14	Various			2002	123,175		20	15,374	15,374	70,482	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			127,860	6,056		4,393	(1,663)	12,170
69				167,565			(167,565)	
70			\$ 436,454	\$ 173,621		\$ 29,717	\$ (143,904)	\$ 167,287

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 436,454	\$ 173,621		\$ 29,717	\$ (143,904)	\$ 167,287	1
2	Awnings	2003	4,905		20	491	491	1,635	2
3	Door Access System	2003	6,000		20	600	600	2,250	3
4	Carpeting	2004	3,648		20	521	521	1,563	4
5	Drywall And Hardware	2004	1,400		20	140	140	420	5
6	Wanderguard System	2004	10,855		20	1,551	1,551	4,006	6
7	Water Heater Repairs	2004	775		20	39	39	110	7
8	Radiator Repairs	2004	1,583		20	79	79	224	8
9	Elevator Repairs	2004	1,153		20	58	58	139	9
10	Therapy Room Mural	2004	1,400		20	70	70	152	10
11	Generator Repairs	2004	940		20	47	47	98	11
12	Doors	2005	353		20	35	35	68	12
13	Fence	2005	1,580		20	158	158	303	13
14	Camera/Vcr Security System	2005	728		20	104	104	191	14
15	Wallguard	2005	643		20	107	107	643	15
16	Wallguard	2005	534		20	134	134	534	16
17	Hvac Equipment	2005	514		20	73	73	122	17
18	Fire Alarm Equipment	2005	1,550		20	221	221	369	18
19	Patio Doors	2005	2,692		20	269	269	426	19
20	Fire Sprinkler	2005	1,090		20	156	156	273	20
21	Granite Top And Wood Shelf	2005	3,220		20	322	322	483	21
22	Handicap Access Ramp	2005	450		20	45	45	64	22
23	Parking Lot	2005	5,285		20	529	529	749	23
24	Carpeting	2005	2,486		20	355	355	503	24
25	Digital Signaling Device	2005	1,057		20	106	106	150	25
26	2 Ton Condenser/Thermostat Misc	2005	866		20	87	87	123	26
27	Floor Tile	2005	18,700		20	1,247	1,247	1,662	27
28	Coffee Table And Wall Molding	2005	3,550		20	355	355	473	28
29	Nurses Station	2005	10,000		20	1,000	1,000	1,333	29
30	Wallcovering	2005	228		20	114	114	228	30
31	Wallcovering	2005	1,512		20	1,008	1,008	1,512	31
32	Wallcovering	2005	4,819		20	2,811	2,811	4,819	32
33	Wallcovering	2005	4,890		20	3,260	3,260	4,890	33
34	TOTAL (lines 1 thru 33)		\$ 535,860	\$ 173,621		\$ 45,809	\$ (127,812)	\$ 197,802	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 535,860	\$ 173,621		\$ 45,809	\$ (127,812)	\$ 197,802	1
2	Chandelier	2005	1,279		20	128	128	171	2
3	Wallcovering	2005	4,597		20	3,065	3,065	4,597	3
4	Sconces	2005	3,335		20	334	334	445	4
5	Wallcovering	2005	6,736		20	4,491	4,491	6,736	5
6	Overhead Light Fixture	2005	2,734		20	273	273	342	6
7	Wallcovering	2005	1,180		20	885	885	1,180	7
8	Tile Floor	2005	19,158		20	1,277	1,277	1,597	8
9	Tile Floor	2005	2,658		20	177	177	236	9
10	Tile Floor	2005	1,240		20	83	83	110	10
11	Tile Floor	2005	1,128		20	75	75	94	11
12	Flooring	2005	37,984		20	2,532	2,532	2,954	12
13	Curtains, Window Treatments	2005	14,141		20	1,414	1,414	2,003	13
14	Magnetic Locks	2005	539		20	54	54	94	14
15	Carpeting	2005	562		20	80	80	87	15
16	Platform Mounted Parallel Bar	2005	1,325		20	133	133	155	16
17	Wallcovering	2005	1,334		20	1,112	1,112	1,334	17
18	Tile Floor	2005	2,239		20	149	149	162	18
19	Tile Floor	2005	852		20	57	57	62	19
20	Tile Floor	2005	1,313		20	88	88	95	20
21	New Floor	2005	9,682		20	645	645	699	21
22	White Medical Cabinet	2005	3,037		20	607	607	860	22
23	Door Entry System	2005	765		20	77	77	147	23
24	Monitoring System/ Video Processor	2005	1,298		20	185	185	294	24
25	Interior Design Service	2005	2,665		20	267	267	378	25
26	Walk-In Freezer	2005	1,299		20	186	186	217	26
27	Wall Mural	2005	2,800		20	280	280	303	27
28	Computer Software	2005	951		20	317	317	370	28
29	Conference Room And Lobby Entrance Improvements	2005	1,250		20	125	125	135	29
30	Improvements To Patients Rooms	2005	1,530		20	153	153	179	30
31	Pegasus Furniture	2005	5,280		20	528	528	572	31
32	Awning System	2006	2,165		20	217	217	217	32
33	Door Entry System	2006	952		20	125	125	125	33
34	TOTAL (lines 1 thru 33)		\$ 673,868	\$ 173,621		\$ 65,928	\$ (107,693)	\$ 224,752	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 673,868	\$ 173,621		\$ 65,928	\$ (107,693)	\$ 224,752	1
2	Wallcoverings	2006	765		20	128	128	128	2
3	Window Shades, Cubicle Track Set	2006	6,110		20	458	458	458	3
4	Flooring	2006	3,097		20	172	172	172	4
5	Flooring And Wallcovering	2006	6,670		20	296	296	296	5
6	Flooring And Wallcovering	2006	6,465		20	251	251	251	6
7	Ada Installation	2006	3,322		20	194	194	194	7
8	Extension Of The Nurses Station	2006	1,600		20	93	93	93	8
9	Awning System Repairs	2006	1,500		20	75	75	75	9
10	Awning System Repairs	2006	2,250		20	113	113	113	10
11	Pipes And Wall Sealing Work	2006	2,000		20	100	100	100	11
12	Signage And Receptacles	2006	2,824		20	94	94	94	12
13	Valves For Refrigeration System	2006	966		20	24	24	24	13
14	2 Magnetic Door Holders	2006	1,775		20	118	118	118	14
15	Wall Mural	2006	750		20	19	19	19	15
16	Wall Mural	2006	750		20	19	19	19	16
17	Flooring	2006	2,000		20	22	22	22	17
18	Flooring	2006	769		20	9	9	9	18
19	20 Amp 120 Volt Circuit & Outlet For 2 New Pa Amplifiers	2006	1,875		20	31	31	31	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)		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12K, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12N, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968	34

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Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12P, Carried Forward	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 719,356	\$ 173,621		\$ 68,144	\$ (105,477)	\$ 226,968		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	Allocated - 7257 N. Lincoln		2004	2004	\$ 97,453	\$ 2,499	35	\$ 2,784	\$ 285	\$ 8,701	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alloc-Nucare Services Corp			2003	811	56	20	41	(15)	127	9
10	Alloc-Nucare Services Corp			2004	16,474	1,140	20	825	(315)	2,234	10
11	Alloc-Nucare Services Corp			2005	977	68	20	49	(19)	90	11
12	Alloc-Nucare Services Corp			2006	1,324	92	20	24	(68)	24	12
13	Allocated - 7257 N. Lincoln			2004	1,937	372	20	97	(275)	242	13
14	Allocated - 7257 N. Lincoln			2005	8,884	1,829	20	573	(1,256)	752	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	127,860	\$	6,056	\$	4,393	\$	(1,663)	\$	12,170	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 861,986	\$ 3,792	\$ 99,789	\$ 95,997	10	\$ 574,693	71
72	Current Year Purchases	129,114	297	14,208	13,911	10	14,208	72
73	Fully Depreciated Assets	16,256				10	16,256	73
74								74
75	TOTALS	\$ 1,007,356	\$ 4,089	\$ 113,997	\$ 109,908		\$ 605,157	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		98 CHEVY VAN	2001	\$ 11,532	\$	\$ 1,153	\$ 1,153	5	\$ 6,246	76
77										77
78										78
79										79
80	TOTALS			\$ 11,532	\$	\$ 1,153	\$ 1,153		\$ 6,246	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)	\$ 1,749,072	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,710	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 183,294	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,584	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 838,371	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Hillside Ltd. Partnership

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>1,214,495</u>			3
4	Additions							4
5	<u>Alloc-Nucare</u>				<u>383</u>			5
6								6
7	TOTAL				\$ <u>1,214,878</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,227 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 314,946	\$		\$ 314,946	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			247,146			247,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			344,942			344,942	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				468,690		468,690	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					13,451	100,097		113,548	13
14	TOTAL			\$		\$ 920,485	\$ 568,787		\$ 1,489,272	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$		1
2	Cash-Patient Deposits		5,124	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)		1,946,741	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		97,622	6
7	Other Prepaid Expenses		170,865	7
8	Accounts Receivable (owners or related parties)		575,890	8
9	Other(specify): See Attached Schedule		280,332	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	3,076,574	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		899,826	15
16	Equipment, at Historical Cost		974,676	16
17	Accumulated Depreciation (book methods)		(1,204,552)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		37,608	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(35,101)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		2,143	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	674,600	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	3,751,174	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	1,232,455	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		(2,833)	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		359,686	30
31	Accrued Taxes Payable (excluding real estate taxes)		40,109	31
32	Accrued Real Estate Taxes(Sch.IX-B)		439,238	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		60,931	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	2,129,586	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		6,032,443	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	6,032,443	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	8,162,029	46
47	TOTAL EQUITY(page 18, line 24)	\$	(4,410,855)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	3,751,174	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,265,399)	1
2	Restatements (describe):		2
3	See Attached	(771,037)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,036,436)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,374,419)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,374,419)	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)	\$ (4,410,855)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/06

Ending: 12/31/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,149,714	1
2	Discounts and Allowances for all Levels	(1,182,547)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,967,167	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,205,286	6
7	Oxygen	5,509	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,210,795	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	798,250	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,156	19
20	Radiology and X-Ray	20,565	20
21	Other Medical Services	96,286	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 942,257	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	36,329	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,329	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,156,614	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,518,607	31
32	Health Care	4,089,567	32
33	General Administration	2,712,289	33
B. Capital Expense			
34	Ownership	2,497,966	34
C. Ancillary Expense			
35	Special Cost Centers	1,618,899	35
36	Provider Participation Fee	93,705	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,531,033	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,374,419)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,374,419)	43

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

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

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

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

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,525	1,665	\$ 81,024	\$ 48.66	1
2	Assistant Director of Nursing	2,817	3,058	114,547	37.46	2
3	Registered Nurses	26,343	28,141	872,123	30.99	3
4	Licensed Practical Nurses	35,523	38,790	1,040,127	26.81	4
5	CNAs & Orderlies	96,358	102,158	1,023,156	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,877	11,482	175,949	15.32	8
9	Activity Director	3,637	4,122	72,931	17.69	9
10	Activity Assistants	9,960	10,735	93,804	8.74	10
11	Social Service Workers	3,685	3,957	153,753	38.86	11
12	Dietician	2,061	2,260	48,225	21.34	12
13	Food Service Supervisor					13
14	Head Cook	5,410	5,814	61,877	10.64	14
15	Cook Helpers/Assistants	21,644	23,120	198,989	8.61	15
16	Dishwashers					16
17	Maintenance Workers	3,761	3,958	56,844	14.36	17
18	Housekeepers	28,122	30,492	296,298	9.72	18
19	Laundry					19
20	Administrator	2,037	2,086	98,636	47.28	20
21	Assistant Administrator					21
22	Other Administrative	2,682	2,731	86,209	31.57	22
23	Office Manager					23
24	Clerical	15,985	5,195	166,093	31.97	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	1,874	2,046	37,052	18.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,642	3,795	125,131	32.97	33
34	TOTAL (lines 1 - 33)	277,943	285,605	\$ 4,802,768 *	\$ 16.82	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	706	\$ 20,919	01-03	35
36	Medical Director	Monthly	32,232	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	454	11,339	10-03	38
39	Pharmacist Consultant	Monthly	3,648	10-03	39
40	Physical Therapy Consultant	44	2,182	10a-03	40
41	Occupational Therapy Consultant	15	734	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	130	10a-03	43
44	Activity Consultant	59	3,265	11-03	44
45	Social Service Consultant	78	4,292	12-03	45
46	Other(specify)				46
47	Developmentally Disabled Cons	19	1,330	12-03	47
48					48
49	TOTAL (lines 35 - 48)	1,377	\$ 84,295		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	76	\$ 3,984	10-03	50
51	Licensed Practical Nurses	3,211	111,527	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,287	\$ 115,511		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$8447
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,911 Line 10-02
- (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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 93,705
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? Yes 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. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT