

		FOR BHF USE					

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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:** 6/30/1997

**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
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**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 01/01/07 to 12/31/07 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 &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>64,970</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>178</u>	TOTALS	<u>178</u>	<u>64,970</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>41,832</u>	<u>3,233</u>	<u>14,245</u>	<u>59,310</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>41,832</u>	<u>3,233</u>	<u>14,245</u>	<u>59,310</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.29%

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 6/30/1997

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

YES  Date 06/30/1997 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 10,975

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	313,282	70,735	15,979	399,996		399,996		399,996		1
2	Food Purchase		302,751		302,751		302,751	(165)	302,586		2
3	Housekeeping	296,196	58,692	4,514	359,402		359,402		359,402		3
4	Laundry		18,409	949	19,358		19,358		19,358		4
5	Heat and Other Utilities			210,066	210,066		210,066	(3,182)	206,884		5
6	Maintenance	62,984	73,140	126,062	262,186		262,186	3,253	265,439		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>672,462</b>	<b>523,727</b>	<b>357,570</b>	<b>1,553,759</b>		<b>1,553,759</b>	<b>(94)</b>	<b>1,553,665</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			61,062	61,062		61,062		61,062		9
10	Nursing and Medical Records	3,345,588	208,609	52,978	3,607,175		3,607,175		3,607,175		10
10a	Therapy	158,574		3,050	161,624		161,624		161,624		10a
11	Activities	177,849	42,196	3,325	223,370		223,370	(26,560)	196,810		11
12	Social Services	161,035		2,330	163,365		163,365		163,365		12
13	CNA Training										13
14	Program Transportation			24,826	24,826		24,826		24,826		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,843,046</b>	<b>250,805</b>	<b>147,571</b>	<b>4,241,422</b>		<b>4,241,422</b>	<b>(26,560)</b>	<b>4,214,862</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	147,395		145,006	292,401		292,401	(84,798)	207,603		17
18	Directors Fees										18
19	Professional Services			117,905	117,905		117,905	(3,856)	114,049		19
20	Dues, Fees, Subscriptions & Promotions			94,530	94,530		94,530	(61,521)	33,009		20
21	Clerical & General Office Expenses	251,316	46,389	275,185	572,890		572,890	(110,960)	461,930		21
22	Employee Benefits & Payroll Taxes			878,256	878,256		878,256	(3,531)	874,725		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,743	2,743		2,743	1,242	3,985		24
25	Other Admin. Staff Transportation			3,168	3,168		3,168	(575)	2,593		25
26	Insurance-Prop.Liab.Malpractice			460,589	460,589		460,589	1,115	461,704		26
27	Other (specify):*							28,153	28,153		27
28	<b>TOTAL General Administration</b>	<b>398,711</b>	<b>46,389</b>	<b>1,977,382</b>	<b>2,422,482</b>		<b>2,422,482</b>	<b>(234,732)</b>	<b>2,187,750</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,914,219</b>	<b>820,921</b>	<b>2,482,523</b>	<b>8,217,663</b>		<b>8,217,663</b>	<b>(261,385)</b>	<b>7,956,278</b>		<b>29</b>

\*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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			156,745	156,745		156,745	24,038	180,783		30
31	Amortization of Pre-Op. & Org.			2,507	2,507		2,507		2,507		31
32	Interest			696,069	696,069		696,069	(12,836)	683,233		32
33	Real Estate Taxes			469,863	469,863		469,863	4,059	473,922		33
34	Rent-Facility & Grounds			1,290,711	1,290,711		1,290,711	389	1,291,100		34
35	Rent-Equipment & Vehicles			8,027	8,027		8,027	2,943	10,970		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,623,922	2,623,922		2,623,922	18,593	2,642,515		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	3,276	543,058	986,842	1,533,176		1,533,176		1,533,176		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			99,180	99,180		99,180	(1,725)	97,455		42
43	Other (specify):*	45,307		1,110	46,417		46,417	(46,417)			43
44	<b>TOTAL Special Cost Centers</b>	48,583	543,058	1,087,132	1,678,773		1,678,773	(48,142)	1,630,631		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,962,802	1,363,979	6,193,577	12,520,358		12,520,358	(290,934)	12,229,424		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:

01/01/07

Ending:

12/31/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,860	30		9
10	Interest and Other Investment Income	(19,132)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	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	(13,124)	21		18
19	Entertainment	(1,583)	21		19
20	Contributions	(14,015)	20		20
21	Owner or Key-Man Insurance	(3,531)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,591)	21		24
25	Fund Raising, Advertising and Promotional	(45,875)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(167,862)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (411,019)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	120,084		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 120,084</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (290,934)</b>		<b>37</b>

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Excess Provider Fee Tax	\$ (1,725)	42	1
2 Waiver	(1,100)	43	2
3 Non-Allowable Office Expense	(25,500)	23	3
4 Miscellaneous Income	(1,214)	23	4
5 Patient Needs	(8,961)	11	5
6 Patient Clothing	(17,599)	11	6
7 Cable	(5,084)	08	7
8 Bank Charges	(7,196)	21	8
9 Annual Report	(438)	20	9
10 CPE Fees	(2,177)	20	10
11 Non-Allowable Seminar Expense	(790)	24	11
12 Non-Allowable Auto	(1,504)	25	12
13 Prior Period and Non-Allowable Legal Fees	(13,473)	19	13
14 2005 & 2006 Seminar from PV Cost Report	556	24	14
15 Non-Allowable Office Expense	(56,239)	23	15
16 Clinical Nurse Evaluation	(32,249)	43	16
17 VP of Program Development	(7,429)	43	17
18 Director of Guest Services	(5,538)	43	18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49			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			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(167,862)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(165)											(165)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,084)		1,902									(3,182)	5
6	Maintenance			3,253									3,253	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(5,249)</b>		<b>5,155</b>									<b>(94)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(26,560)											(26,560)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(26,560)</b>											<b>(26,560)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(54,264)	(18,054)	(12,480)							(84,798)	17
18	Directors Fees													18
19	Professional Services	(13,473)		9,316	455	(154)							(3,856)	19
20	Fees, Subscriptions & Promotions	(62,505)		966		19							(61,521)	20
21	Clerical & General Office Expenses	(245,547)		133,085	1,038	464							(110,960)	21
22	Employee Benefits & Payroll Taxes	(3,531)											(3,531)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(234)		1,476									1,242	24
25	Other Admin. Staff Transportation	(1,505)		930									(575)	25
26	Insurance-Prop.Liab.Malpractice			1,115									1,115	26
27	Other (specify):*			25,252	876	2,025							28,153	27
28	<b>TOTAL General Administration</b>	<b>(326,795)</b>		<b>117,875</b>	<b>(15,685)</b>	<b>(10,126)</b>							<b>(234,732)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(358,605)</b>		<b>123,030</b>	<b>(15,685)</b>	<b>(10,126)</b>							<b>(261,385)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	14,860		9,178									24,038	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,132)		6,296									(12,836)	32
33	Real Estate Taxes			4,059									4,059	33
34	Rent-Facility & Grounds			389									389	34
35	Rent-Equipment & Vehicles			2,943									2,943	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(4,272)</b>		<b>22,865</b>									<b>18,593</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(1,725)											(1,725)	42
43	Other (specify):*	(46,417)											(46,417)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(48,142)</b>											<b>(48,142)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(411,019)</b>		<b>145,895</b>	<b>(15,685)</b>	<b>(10,126)</b>							<b>(290,934)</b>	<b>45</b>

**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: 01/01/07 Ending: 12/31/07

## 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%	\$ 1,902	\$ 1,902	15
16	V	6 REPAIRS AND MAINT.				3,253	3,253	16
17	V	17 ADMIN. - NON-OWNER				23,443	23,443	17
18	V	19 PROFESSIONAL FEES				9,316	9,316	18
19	V	20 FEES SUBSCRIPTIONS				966	966	19
20	V	21 CLERICAL & GENERAL				133,085	133,085	20
21	V	24 SEMINARS AND EDUCATION				1,476	1,476	21
22	V	25 ADMIN. STAFF TRAVEL				930	930	22
23	V	26 INSURANCE				1,115	1,115	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.				17,887	17,887	24
25	V	30 DEPRECIATION				9,178	9,178	25
26	V	32 INTEREST EXPENSE				6,296	6,296	26
27	V	33 REAL ESTATE TAX				4,059	4,059	27
28	V	34 PARKING LOT RENT				389	389	28
29	V	35 EQUIPMENT RENTAL				2,943	2,943	29
30	V	17 ADMIN. - R. HARTMAN				12,178	12,178	30
31	V	17 ADMIN. - B. CARR				6,901	6,901	31
32	V	17 ADMIN. - D. HARTMAN						32
33	V	27 EMP. BEN. - R. HARTMAN				5,925	5,925	33
34	V	27 EMP. BEN. - B. CARR				1,440	1,440	34
35	V	27 EMP. BEN. - D. HARTMAN						35
36	V							36
37	V	17 Management Fees	96,786				(96,786)	37
38	V							38
39	Total		\$ 96,786			\$ 242,681	\$ * 145,895	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: 01/01/07 Ending: 12/31/07

## 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				455	455	16
17	V	21 OFFICE				1,038	1,038	17
18	V	27 PAYROLL TAXES				876	876	18
19	V							19
20	V	17 C. RAJCHENBACH-COMP.						20
21	V	27 PAYROLL TAXES						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	25,500				(25,500)	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		\$ 25,500			\$ 9,815	\$ * (15,685)	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%	\$ 10,240	\$ 10,240	15
16	V	19 PROFESSIONAL FEES				(154)	(154)	16
17	V	20 DUES AND SUBSCRIPRTIONS				19	19	17
18	V	21 CLERICAL AND GENERAL				464	464	18
19	V	27 GEN ADMIN.- EMP. BEN.				2,025	2,025	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V	17 MANAGEMENT FEES	22,720				(22,720)	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		\$ 22,720			\$ 12,594	\$ * (10,126)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workmans Compensation	\$ 77,012	Diamond Insurance		\$ 77,012	\$	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			\$ 77,012			\$ 77,012	\$ *	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.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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	0.68	1.36%	Alloc-Nucare	\$ 12,178	17-7	1
2	Jack Rajchenbach	Owner	Administrative	25.00	See Attached	5	7.69%	Alloc-JLR	7,445	17-7	2
3	Bernard Hollander	Owner	Administrative	25.00	See Attached	2	3.08%				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,623		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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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 960,286	12	\$ 28,115	\$	64,970	\$ 1,902	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 960,286	12	48,079		64,970	3,253	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS 960,286	12	346,499	346,499	64,970	23,443	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 960,286	12	137,702		64,970	9,316	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 960,286	12	14,277		64,970	966	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 960,286	12	1,967,057	1,688,717	64,970	133,085	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 960,286	12	21,810		64,970	1,476	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 960,286	12	13,739		64,970	930	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 960,286	12	16,477		64,970	1,115	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 960,286	12	264,372		64,970	17,887	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 960,286	12	135,649		64,970	9,178	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 960,286	12	93,063		64,970	6,296	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 960,286	12	60,000		64,970	4,059	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 960,286	12	5,749		64,970	389	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 960,286	12	43,501		64,970	2,943	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 10	12	180,000	180,000	64,970	12,178	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	12	102,000	102,000	64,970	6,901	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	80,000	80,000	64,970		18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 10	12	87,577		64,970	5,925	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	12	21,286		64,970	1,440	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	16,421		64,970		21
22									22
23									23
24									24
25	TOTALS				\$ 3,683,372	\$ 2,397,215		\$ 242,681	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	9,634		5	876	4
5										5
6										6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED	40	1	59,667	59,667			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED	40	1	4,736				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					\$ 172,351	\$ 152,981		\$ 9,815	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

# 0042176

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	388,800	9	\$ 175,237	\$ 175,237	22,720	\$ 10,240	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	388,800	9	(2,628)		22,720	(154)	2
3	20	DUES AND SUBSCRIPRTIONS	CARE PATH FEES	388,800	9	332		22,720	19	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	388,800	9	7,946		22,720	464	4
5	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	388,800	9	34,646		22,720	2,025	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					\$ 215,533	\$ 175,237		\$ 12,594	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Shareholder Loan		X				\$	\$ 6,287,708			\$ 605,409	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	<b>Working Capital</b>											
6	Sun Joint Venture		X								60,440	6
7	Hillside Ltd. Partnership		X								30,220	7
8	See Supplemental Schedule											8
9	<b>TOTAL Facility Related</b>						\$	\$ 6,287,708			\$ 696,069	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income		X								(19,132)	10
11	Alloc. From Nucare										6,296	11
12												12
13	See Supplemental Schedule											13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(12,836)	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 6,287,708			\$ 683,233	15

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

\* 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:

01/01/07

Ending:

12/31/07

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

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

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

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

\*\* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-17-101-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>513,964.56</u>	\$ <u>451,672.06</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>100,273.68</u>	\$ <u>6,784.21</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>614,238.24</u>	\$ <u>458,456.27</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Renaissance at Hillside

# 0042176 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

Hillside Assisted Living Center, Ltd - Assisted Living Center was closed in May 2005  
Hillside Montessori School - Child Day Care

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

1. Total Amount Incurred: 37,608 2. Number of Years Over Which it is Being Amortized: 5  
 3. Current Period Amortization: 2,507 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 from 7257 N. Lincoln</u>		<u>2004</u>	<u>\$ 10,825</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 10,825</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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
	<b>Improvement Type**</b>										
9	Various			1997	12,990		20	650	650	6,731	9
10	Various			1998	40,341		20	2,017	2,017	19,213	10
11	Various			1999	52,100		20	2,606	2,606	22,395	11
12	Various			2000	30,099		20	2,181	2,181	29,637	12
13	Various			2001	49,889		20	2,496	2,496	16,605	13
14	Various			2002	123,175		20	12,291	12,291	82,772	14
15	Various			2003	10,905		20	1,091	1,091	4,976	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:

01/01/07

Ending:

12/31/07

**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		127,371	4,560		4,412	(148)	16,521	68
69			156,745			(156,745)		69
70		\$ 446,870	\$ 161,305		\$ 27,744	\$ (133,561)	\$ 198,850	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 446,870	\$ 161,305		\$ 27,744	\$ (133,561)	\$ 198,850	1
2	Carpeting	2004	3,648		20	521	521	2,085	2
3	Drywall And Hardware	2004	1,400		20	140	140	560	3
4	Wanderguard System	2004	10,855		20	1,551	1,551	5,557	4
5	Water Heater Repairs	2004	775		20	39	39	149	5
6	Radiator Repairs	2004	1,583		20	79	79	303	6
7	Elevator Repairs	2004	1,153		20	58	58	197	7
8	Therapy Room Mural	2004	1,400		20	70	70	222	8
9	Generator Repairs	2004	940		20	47	47	145	9
10	Doors	2005	353		20	35	35	103	10
11	Fence	2005	1,580		20	158	158	461	11
12	Camera/Vcr Security System	2005	728		20	104	104	295	12
13	Wallguard	2005	643		20			643	13
14	Wallguard	2005	534		20			534	14
15	Hvac Equipment	2005	514		20	73	73	196	15
16	Fire Alarm Equipment	2005	1,550		20	221	221	590	16
17	Patio Doors	2005	2,692		20	269	269	695	17
18	Fire Sprinkler	2005	1,090		20	156	156	428	18
19	Granite Top And Wood Shelf	2005	3,220		20	322	322	805	19
20	Handicap Access Ramp	2005	450		20	45	45	109	20
21	Parking Lot	2005	5,285		20	529	529	1,277	21
22	Carpeting	2005	2,486		20	355	355	858	22
23	Digital Signaling Device	2005	1,057		20	106	106	255	23
24	2 Ton Condenser/Thermostat Misc	2005	866		20	87	87	209	24
25	Floor Tile	2005	18,700		20	1,247	1,247	2,909	25
26	Coffee Table And Wall Molding	2005	3,550		20	355	355	828	26
27	Nurses Station	2005	10,000		20	1,000	1,000	2,333	27
28	Wallcovering	2005	228		20			228	28
29	Wallcovering	2005	1,512		20			1,512	29
30	Wallcovering	2005	4,819		20			4,819	30
31	Wallcovering	2005	4,890		20			4,890	31
32	Chandelier	2005	1,279		20	128	128	298	32
33	Wallcovering	2005	4,597		20			4,597	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 541,247	\$ 161,305		\$ 35,439	\$ (125,866)	\$ 237,940	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 541,247	\$ 161,305		\$ 35,439	\$ (125,866)	\$ 237,940	1
2	Sconces	2005	3,335		20	334	334	778	2
3	Wallcovering	2005	6,736		20			6,736	3
4	Overhead Light Fixture	2005	2,734		20	273	273	615	4
5	Wallcovering	2005	1,180		20			1,180	5
6	Tile Floor	2005	19,158		20	1,277	1,277	2,874	6
7	Tile Floor	2005	2,658		20	177	177	413	7
8	Tile Floor	2005	1,240		20	83	83	193	8
9	Tile Floor	2005	1,128		20	75	75	169	9
10	Flooring	2005	37,984		20	2,532	2,532	5,487	10
11	Curtains, Window Treatments	2005	14,141		20	1,414	1,414	3,417	11
12	Magnetic Locks	2005	539		20	54	54	148	12
13	Carpeting	2005	562		20	80	80	167	13
14	Platform Mounted Parallel Bar	2005	1,325		20	133	133	287	14
15	Wallcovering	2005	1,334		20			1,334	15
16	Tile Floor	2005	2,239		20	149	149	311	16
17	Tile Floor	2005	852		20	57	57	118	17
18	Tile Floor	2005	1,313		20	88	88	182	18
19	New Floor	2005	9,682		20	645	645	1,345	19
20	White Medical Cabinet	2005	3,037		20	607	607	1,468	20
21	Door Entry System	2005	765		20	77	77	223	21
22	Monitoring System/ Video Processor	2005	1,298		20	185	185	479	22
23	Interior Design Service	2005	2,665		20	267	267	644	23
24	Walk-In Freezer	2005	1,299		20	186	186	402	24
25	Wall Mural	2005	2,800		20	280	280	583	25
26	Computer Software	2005	951		20	317	317	687	26
27	Conference Room And Lobby Entrance Improvements	2005	1,250		20	125	125	260	27
28	Improvements To Patients Rooms	2005	1,530		20	153	153	332	28
29	Pegasus Furniture	2005	5,280		20	528	528	1,100	29
30	Awning System	2006	2,165		20	217	217	433	30
31	Door Entry System	2006	952		20	136	136	261	31
32	Wallcoverings	2006	765		20	153	153	281	32
33	Window Shades, Cubicle Track Set	2006	6,110		20	611	611	1,069	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 680,254	\$ 161,305		\$ 46,652	\$ (114,653)	\$ 271,916	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 680,254	\$ 161,305		\$ 46,652	\$ (114,653)	\$ 271,916	1
2	Flooring	2006	3,097		20	206	206	379	2
3	Flooring And Wallcovering	2006	6,670		20	445	445	741	3
4	Flooring And Wallcovering	2006	6,465		20	431	431	682	4
5	Ada Installation	2006	3,322		20	332	332	526	5
6	Extension Of The Nurses Station	2006	1,600		20	160	160	253	6
7	Awning System Repairs	2006	1,500		20	150	150	225	7
8	Awning System Repairs	2006	2,250		20	225	225	338	8
9	Pipes And Wall Sealing Work	2006	2,000		20	200	200	300	9
10	Signage And Receptacles	2006	2,824		20	282	282	376	10
11	Valves For Refrigeration System	2006	966		20	97	97	121	11
12	2 Magnetic Door Holders	2006	1,775		20	178	178	296	12
13	Wall Mural	2006	750		20	75	75	94	13
14	Wall Mural	2006	750		20	75	75	94	14
15	Flooring	2006	2,000		20	133	133	156	15
16	Flooring	2006	769		20	51	51	60	16
17	20 Amp 120 Volt Circuit & Outlet For 2 New Pa Amplifiers	2006	1,875		20	188	188	219	17
18	Hinges & Align 4 Doors	2007	3,384		20	338	338	338	18
19	Hydrocollator	2007	2,500		20	250	250	250	19
20	Outlet For Stove In Therapy Room	2007	1,250		20	125	125	125	20
21	Double Pre-Hung Doors	2007	942		20	86	86	86	21
22	Painted Elevator Hallway	2007	1,675		20	154	154	154	22
23	Painted Elevator Hallway	2007	1,675		20	140	140	140	23
24	Kitchen Cabinets	2007	2,500		20	250	250	250	24
25	Drywall	2007	2,225		20	223	223	223	25
26	Wall Openings	2007	2,250		20	206	206	206	26
27	Shaw Rambler Rug*	2007	478		20	40	40	40	27
28	Armstrong/Congoleum/Adhesive Vinyl Title	2007	1,374		20	115	115	115	28
29	Winpak Software Upgrade	2007	7,752		20	775	775	775	29
30	Cabinets - Dining Rooms	2007	9,600		20	880	880	880	30
31	Vct Tiles	2007	2,920		20	219	219	219	31
32	Carpeting	2007	2,200		20	165	165	165	32
33	Volt Circuit	2007	1,200		20	100	100	100	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 762,792	\$ 161,305		\$ 53,946	\$ (107,359)	\$ 280,842	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 762,792	\$ 161,305		\$ 53,946	\$ (107,359)	\$ 280,842	1
2	Wall And Flooring	2007	1,800		20	135	135	135	2
3	Wall Covering	2007	2,022		20	152	152	152	3
4	Wall Paper	2007	3,960		20	264	264	264	4
5	Wall Paper	2007	3,360		20	224	224	224	5
6	Vct Tile	2007	2,148		20	143	143	143	6
7	Vct Tile	2007	2,838		20	189	189	189	7
8	Wallcoverings	2007	2,780		20	185	185	185	8
9	Circuit For Portable Heater	2007	1,600		20	107	107	107	9
10	Elevator Repairing	2007	4,218		20	422	422	422	10
11	Furnace*	2007	3,885		20	324	324	324	11
12	Fantagraph Pleated Shades And Accessories*	2007	3,504		20	204	204	204	12
13	Fantagraph Pleated Shades And Accessories*	2007	1,426		20	119	119	119	13
14	Fantagraph Pleated Shades And Accessories*	2007	1,383		20	104	104	104	14
15	Wiring And Fixture For Complete Electrical System For Sign Illum	2007	2,900		20	169	169	169	15
16	Crown Molding*	2007	2,137		20	107	107	107	16
17	Mural Design For Dementia Unit*	2007	2,400		20	120	120	120	17
18	Conduit Wire For 50A Range Receptacle For Physical Therapy R	2007	1,850		20	93	93	93	18
19	Valance & Controls Size*	2007	5,409		20	180	180	180	19
20	Roof Sign Lighting Project*	2007	2,950		20	98	98	98	20
21	Wood Cabinets*	2007	6,380		20	372	372	372	21
22	Reface Nursing Stations*	2007	3,980		20	133	133	133	22
23	Arbour Faux 2' Wood Blind*	2007	171		20	6	6	6	23
24	Arbour Faux Wood Blinds*	2007	1,262		20	32	32	32	24
25	Arbour Faux Wood Blinds*	2007	6,038		20	101	101	101	25
26	Furnish/Install Lake Forest Wood Blind*	2007	175		20	7	7	7	26
27	Furnish/Install Main Card Reader Panel Replacement*	2007	4,100		20	273	273	273	27
28	Built-In Binty Sop Cabinets Laminate*	2007	2,450		20	20	20	20	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12M, Carried Forward</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12O, Carried Forward</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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)		\$ 839,918	\$ 161,305		\$ 58,229	\$ (103,076)	\$ 285,125	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:

01/01/07

Ending:

12/31/07

**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
	<b>Improvement Type**</b>										
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:

01/01/07

Ending:

12/31/07

**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	<b>TOTAL (lines 4 thru 69)</b>		\$	\$	\$	\$	\$	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:

01/01/07

Ending:

12/31/07

**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 from 7257 N. Lincoln Avenue, LLC		2004	2004	\$ 97,426	\$ 2,498	35	\$ 2,784	\$ 286	\$ 11,482	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated from Nucare Services Corp.			2003	792	29	20	40	11	163	9
10	Allocated from Nucare Services Corp.			2004	16,089	588	20	805	217	2,988	10
11	Allocated from Nucare Services Corp.			2005	954	35	20	48	13	136	11
12	Allocated from Nucare Services Corp.			2006	1,293	47	20	65	18	88	12
13											13
14	Allocated from 7257 N. Lincoln Avenue, LLC			2004	1,936	223	20	97	(126)	339	14
15	Allocated from 7257 N. Lincoln Avenue, LLC			2005	8,881	1,140	20	573	(567)	1,325	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:

01/01/07

Ending:

12/31/07

**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)	\$	127,371	\$	4,560	\$	4,412	\$	(148)	\$	16,521	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: 01/01/07 Ending: 12/31/07

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	\$ 988,316	\$ 4,243	\$ 105,516	\$ 101,273	10	\$ 692,161	71
72	Current Year Purchases	124,967	376	15,833	15,457	10	15,833	72
73	Fully Depreciated Assets	18,004		53	53	10	18,004	73
74								74
75	TOTALS	\$ 1,131,287	\$ 4,619	\$ 121,402	\$ 116,783		\$ 725,998	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	\$ 7,399	76
77										77
78										78
79										79
80	TOTALS			\$ 11,532	\$	\$ 1,153	\$ 1,153		\$ 7,399	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)	\$ 1,993,562	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,784	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,860	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,018,522	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:				\$ 1,288,712			3
4	Additions							4
5	Storage Rental				1,999			5
6	Alloc. Nucare				389			6
7	TOTAL				\$ 1,291,100			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 10,970 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?</p> <p style="text-align: right;"> <input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO             </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 335,713	\$		\$ 335,713	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			216,271	6,802		223,073	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			409,150			409,150	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				430,082		430,082	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			3,276		25,708	106,174		135,158	13
14	TOTAL			\$ 3,276		\$ 986,842	\$ 543,058		\$ 1,533,176	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits		5,124	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )		2,580,459	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		110,238	6
7	Other Prepaid Expenses		24,398	7
8	Accounts Receivable (owners or related parties)		(426,007)	8
9	Other(specify): <a href="#">See Attached Schedule</a>		391,874	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	2,686,086	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		1,020,875	15
16	Equipment, at Historical Cost		1,096,545	16
17	Accumulated Depreciation (book methods)		(1,361,297)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		37,608	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(37,608)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>		2,143	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	758,266	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	3,444,352	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	870,637	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		413,571	30
31	Accrued Taxes Payable (excluding real estate taxes)		30,333	31
32	Accrued Real Estate Taxes(Sch.IX-B)		456,811	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		103	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>		80,910	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	1,849,532	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		6,287,708	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	6,287,708	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	8,137,240	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	(4,692,888)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	3,444,352	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,410,855)	1
2	Restatements (describe):		2
3	See Attached	(4,622)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,415,477)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(277,411)	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)	\$ (277,411)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (4,692,888)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Renaissance at Hillside

# 0042176

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,956,190	1
2	Discounts and Allowances for all Levels	(1,140,196)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,815,994	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,392,682	6
7	Oxygen	1,813	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,394,495	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	824,378	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,241	19
20	Radiology and X-Ray	20,153	20
21	Other Medical Services	69,569	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 951,341	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	19,132	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19,132	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	61,985	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 61,985	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,242,947	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,553,759	31
32	Health Care	4,241,422	32
33	General Administration	2,422,482	33
<b>B. Capital Expense</b>			
34	Ownership	2,623,922	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,579,593	35
36	Provider Participation Fee	99,180	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 12,520,358	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(277,411)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (277,411)	43

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. 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: 01/01/07

Ending:

12/31/07

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	1,981	2,206	\$ 100,173	\$ 45.41	1
2	Assistant Director of Nursing	1,230	1,304	51,381	39.40	2
3	Registered Nurses	32,486	35,573	1,049,222	29.49	3
4	Licensed Practical Nurses	34,630	38,642	1,017,680	26.34	4
5	CNAs & Orderlies	108,061	116,086	1,089,045	9.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,566	10,098	158,574	15.70	8
9	Activity Director	3,552	4,141	75,493	18.23	9
10	Activity Assistants	9,342	10,569	102,356	9.68	10
11	Social Service Workers	3,775	4,542	161,035	35.45	11
12	Dietician	1,900	2,070	49,095	23.72	12
13	Food Service Supervisor					13
14	Head Cook	5,330	6,080	65,872	10.83	14
15	Cook Helpers/Assistants	20,151	22,106	198,315	8.97	15
16	Dishwashers					16
17	Maintenance Workers	4,066	4,279	62,984	14.72	17
18	Housekeepers	27,692	30,508	296,196	9.71	18
19	Laundry					19
20	Administrator	1,973	2,086	98,415	47.18	20
21	Assistant Administrator					21
22	Other Administrative	838	854	48,980	57.35	22
23	Office Manager					23
24	Clerical	9,514	11,269	251,316	22.30	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	1,879	2,052	38,087	18.56	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,437	1,437	48,583	33.81	33
34	TOTAL (lines 1 - 33)	279,403	305,902	\$ 4,962,802 *	\$ 16.22	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	563	\$ 15,979	01-03	35
36	Medical Director	Monthly	61,062	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	413	10,567	10-03	38
39	Pharmacist Consultant	Monthly	4,119	10-03	39
40	Physical Therapy Consultant	29	1,908	10a-03	40
41	Occupational Therapy Consultant	2	101	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,041	10a-03	43
44	Activity Consultant	61	3,325	11-03	44
45	Social Service Consultant	43	2,330	12-03	45
46	Other(specify) Medical Consultant	Monthly	7,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,131	\$ 111,656		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	23	\$ 1,266	10-03	50
51	Licensed Practical Nurses	655	25,802	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	678	\$ 27,068		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Renaissance at Hillside

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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 - \$9,043.06
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,723 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 97,455  
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT