

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	188	Skilled (SNF)	188	68,620	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	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	47,840	1,387	12,707	61,934	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	47,840	1,387	12,707	61,934	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.26%

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 188 and days of care provided 9,238

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/09 Ending: 12/31/09

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
	A. General Services										
1	Dietary	352,246	121,963	19,618	493,827		493,827		493,827		1
2	Food Purchase		313,963		313,963		313,963	(3,664)	310,299		2
3	Housekeeping	342,514	72,284		414,798		414,798		414,798		3
4	Laundry		17,540	2,083	19,623		19,623		19,623		4
5	Heat and Other Utilities			189,041	189,041		189,041	(7,435)	181,606		5
6	Maintenance	91,469	76,457	166,119	334,045		334,045	26,573	360,618		6
7	Other (specify):*										7
8	TOTAL General Services	786,229	602,207	376,861	1,765,297		1,765,297	15,474	1,780,771		8
	B. Health Care and Programs										
9	Medical Director			29,621	29,621		29,621		29,621		9
10	Nursing and Medical Records	3,669,228	256,338	34,689	3,960,255		3,960,255	18,482	3,978,737		10
10a	Therapy	158,850			158,850		158,850		158,850		10a
11	Activities	198,063	46,509	5,992	250,564		250,564	(27,241)	223,323		11
12	Social Services	136,178		4,340	140,518		140,518		140,518		12
13	CNA Training										13
14	Program Transportation			5,846	5,846		5,846		5,846		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,162,319	302,847	80,488	4,545,654		4,545,654	(8,759)	4,536,895		16
	C. General Administration										
17	Administrative	121,455		119,515	240,970		240,970	(95,691)	145,279		17
18	Directors Fees										18
19	Professional Services			155,541	155,541	(8,333)	147,208	(41,072)	106,136		19
20	Dues, Fees, Subscriptions & Promotions			122,963	122,963		122,963	(86,195)	36,768		20
21	Clerical & General Office Expenses	210,965	52,255	285,336	548,556		548,556	(79,606)	468,950		21
22	Employee Benefits & Payroll Taxes			1,010,283	1,010,283		1,010,283		1,010,283		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,121	14,121		14,121	141	14,262		24
25	Other Admin. Staff Transportation			21	21		21	874	895		25
26	Insurance-Prop.Liab.Malpractice			715,895	715,895		715,895	1,841	717,736		26
27	Other (specify):*							34,082	34,082		27
28	TOTAL General Administration	332,420	52,255	2,423,675	2,808,350	(8,333)	2,800,017	(265,626)	2,534,391		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,280,968	957,309	2,881,024	9,119,301	(8,333)	9,110,968	(258,912)	8,852,056		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Renaissance at Hillside

#0042176

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			168,985	168,985		168,985	17,544	186,529			30
31	Amortization of Pre-Op. & Org.			3,013	3,013		3,013		3,013			31
32	Interest			427,489	427,489		427,489	(25,063)	402,426			32
33	Real Estate Taxes			562,822	562,822	8,333	571,155	6,168	577,323			33
34	Rent-Facility & Grounds			1,423,246	1,423,246		1,423,246	344	1,423,590			34
35	Rent-Equipment & Vehicles			24,111	24,111		24,111	2,959	27,070			35
36	Other (specify):*											36
37	TOTAL Ownership			2,609,666	2,609,666	8,333	2,617,999	1,953	2,619,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	13,258	580,787	1,089,359	1,683,404		1,683,404	(4,380)	1,679,024			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*	78,146		27,917	106,063		106,063	(106,063)				43
44	TOTAL Special Cost Centers	91,404	580,787	1,220,206	1,892,397		1,892,397	(110,443)	1,781,954			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,372,372	1,538,096	6,710,896	13,621,364		13,621,364	(367,402)	13,253,962			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:

01/01/09

Ending:

12/31/09

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	(9,372)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,536	30		9
10	Interest and Other Investment Income	(29,334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(2,300)	21		18
19	Entertainment	(2,420)	21		19
20	Contributions	(19,875)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(176,979)	21		24
25	Fund Raising, Advertising and Promotional	(61,388)	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	(200,035)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (491,237)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	123,835		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 123,835		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (367,402)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Renaissance at Hillside

ID# 0042176
 Report Period Beginning: 01/01/09
 Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (169)	21	1
2	Patient Needs	(12,186)	11	2
3	Patient Clothing	(15,055)	11	3
4	Bank Charges	(15,823)	21	4
5	Out of State Seminars	(454)	24	5
6	Medical Records Copies	(462)	10	6
7	Food Rebate	(3,594)	02	7
8	Jury Duty	(189)	10	8
9	Goods Sold	(75)	10	9
10	Guest Services	(78,146)	43	10
11	Non-Allowable Office Expense	(12,000)	21	11
12	COPE Dues	(5,561)	20	12
13	Annual Report	(225)	20	13
14	Capitalized R&M	(10,679)	06	14
15	Out of Period Legal Fees	(5,513)	19	15
16	Marketing Services	(27,917)	43	16
17	Therapy Income	(4,380)	39	17
18	Additional R&M	30,776	06	18
19	Non-Allowable Legal	(38,371)	19	19
20	Marketing Travel	(12)	25	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(200,035)		49

Renaissance at Hillside

ID# 0042176

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,664)											(3,664)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,372)			1,937								(7,435)	5
6	Maintenance	20,097			6,476								26,573	6
7	Other (specify):*													7
8	TOTAL General Services	7,061			8,413								15,474	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(726)				19,208							18,482	10
10a	Therapy													10a
11	Activities	(27,241)											(27,241)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(27,967)				19,208							(8,759)	16
	C. General Administration													
17	Administrative			(7,741)	(77,725)	(10,225)							(95,691)	17
18	Directors Fees													18
19	Professional Services	(43,884)		463	2,137	212							(41,072)	19
20	Fees, Subscriptions & Promotions	(87,049)			757	97							(86,195)	20
21	Clerical & General Office Expenses	(209,691)		1,157	116,604	12,324							(79,606)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(454)			475	120							141	24
25	Other Admin. Staff Transportation	(12)			465	420							874	25
26	Insurance-Prop.Liab.Malpractice				1,841								1,841	26
27	Other (specify):*			999	28,109	4,974							34,082	27
28	TOTAL General Administration	(341,090)		(5,122)	72,664	7,922							(265,626)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(361,996)		(5,122)	81,077	27,130							(258,912)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,536			6,871	137							17,544	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(29,334)			4,046	225							(25,063)	32
33	Real Estate Taxes				6,168								6,168	33
34	Rent-Facility & Grounds				344								344	34
35	Rent-Equipment & Vehicles				2,959								2,959	35
36	Other (specify):*													36
37	TOTAL Ownership	(18,798)			20,389	362							1,953	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(4,380)											(4,380)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(106,063)											(106,063)	43
44	TOTAL Special Cost Centers	(110,443)											(110,443)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(491,237)		(5,122)	101,466	27,492							(367,402)	45

VII. RELATED PARTIES

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

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

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

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

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

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

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%	\$ 9,259	\$	9,259	15
16	V	19 PROFESSIONAL FEES				463		463	16
17	V	21 OFFICE				1,157		1,157	17
18	V	27 PAYROLL TAXES				999		999	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	17,000					(17,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 17,000			\$ 11,878	\$ *	(5,122)	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	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 1,937	\$ 1,937
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	6,476	6,476
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	14,565	14,565
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,137	2,137
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	757	757
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	116,604	116,604
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	475	475
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	465	465
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,841	1,841
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	28,109	28,109
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	6,871	6,871
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	4,046	4,046
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,168	6,168
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	344	344
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,959	2,959
30	V						
31	V	17 Administrative Fees	92,290	NUCARE SERVICES CORP.	100.00%		(92,290)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 92,290			\$ 193,756	\$ * 101,466

* 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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 19,208	\$	19,208	15
16	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	212		212	16
17	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	97		97	17
18	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	11,557		11,557	18
19	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	767		767	19
20	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	120		120	20
21	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	420		420	21
22	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,135		2,135	22
23	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,839		2,839	23
24	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	137		137	24
25	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	225		225	25
26	V								26
27	V	17 Administrative Fees	10,225	CLINICAL CONSULTING SERVICES, LLC	100.00%			(10,225)	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		\$ 10,225			\$ 37,717	\$ *	27,492	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

01/01/09

Ending:

12/31/09

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	David Hartman	Relative	Administrative	0	See Attached	2.24	5.60%	Alloc. Salary	\$ None	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED 54	9	\$ 100,000	\$ 100,000	5	\$ 9,259	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 54	9	5,000		5	463	2
3	21	OFFICE	AVG. HOURS WORKED 54	9	12,497	12,497	5	1,157	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED 54	9	10,792		5	999	4
5									5
6									6
7	17	C. RAJCHENBACH-COMP.	AVG. HOURS WORKED 40	1	51,889	51,889			7
8	27	PAYROLL TAXES	AVG. HOURS WORKED 40	1	4,099				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				\$ 184,277	\$ 164,386		\$ 11,878	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS 1,224,940	13	\$ 34,570	\$	68,620	\$ 1,937	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 1,224,940	13	115,610		68,620	6,476	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS 1,224,940	13	260,001	260,001	68,620	14,565	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,224,940	13	38,148		68,620	2,137	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 1,224,940	13	13,506		68,620	757	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 1,224,940	13	2,081,498	1,811,576	68,620	116,604	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 1,224,940	13	8,486		68,620	475	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 1,224,940	13	8,304		68,620	465	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 1,224,940	13	32,870		68,620	1,841	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 1,224,940	13	501,784		68,620	28,109	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,224,940	13	122,648		68,620	6,871	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 1,224,940	13	72,233		68,620	4,046	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 1,224,940	13	110,113		68,620	6,168	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 1,224,940	13	6,145		68,620	344	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 1,224,940	13	52,826		68,620	2,959	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,458,744	\$ 2,071,577		\$ 193,756	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,224,940	13	\$ 342,887	\$ 68,620	\$ 19,208	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,224,940	13	3,780	68,620	212	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	1,224,940	13	1,732	68,620	97	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,224,940	13	206,311	68,620	11,557	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	13,685	68,620	767	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	1,224,940	13	2,134	68,620	120	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	7,503	68,620	420	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,224,940	13	38,113	68,620	2,135	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,224,940	13	50,678	68,620	2,839	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,224,940	13	2,448	68,620	137	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,224,940	13	4,013	68,620	225	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					\$ 673,284	\$ 549,198	\$ 37,717	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Alloc. From NuCare		X							\$ 4,046	8									
9	Alloc. From Clinical Consult		X							225	9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15											15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning:

01/01/09 Ending:

12/31/09

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: 3,013 4. Dates Incurred: 2002

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 7257 N. Lincoln</u>		<u>2004</u>	<u>\$ 8,067</u>	<u>1</u>
2	<u>Allocated from Clinical Consulting</u>		<u>2004</u>	<u>448</u>	<u>2</u>
3	TOTALS			\$ 8,515	3

SEE ACCOUNTANTS' COMPILATION REPORT

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1997	12,990		20	650	650	8,029	9
10	Various		1998	40,341		20	2,017	2,017	23,247	10
11	Various		1999	52,100		20	2,606	2,606	27,602	11
12	Various		2000	30,099		20	2,181	2,181	33,995	12
13	Various		2001	49,889		20	2,496	2,496	21,593	13
14	Various		2002	123,175		20	9,119	9,119	101,097	14
15	Various		2003	10,905		20	1,091	1,091	7,157	15
16	Various		2004	21,754		20	2,505	2,505	14,226	16
17	Various		2005	201,638		20	14,969	14,969	92,010	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

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	Related Building Company (Pages 12F & 12G)							67	
68	Related Party Allocations (Pages 12H & 12I)		102,508	3,185		4,253	1,068	20,232	68
69	Financial Statement Depreciation			168,985			(168,985)		69
70	TOTAL (lines 4 thru 69)		\$ 645,399	\$ 172,170		\$ 41,887	\$ (130,283)	\$ 349,188	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 645,399	\$ 172,170		\$ 41,887	\$ (130,283)	\$ 349,188	1
2	Awning System	2006	2,165		20	217	217	866	2
3	Door Entry System	2006	952		20	136	136	533	3
4	Wallcoverings	2006	765		20	153	153	587	4
5	Window Shades, Cubicle Track Set	2006	6,110		20	611	611	2,291	5
6	Flooring	2006	3,097		20	206	206	791	6
7	Flooring And Wallcovering	2006	6,670		20	445	445	1,630	7
8	Flooring And Wallcovering	2006	6,465		20	431	431	1,544	8
9	Ada Installation	2006	3,322		20	332	332	1,190	9
10	Extension Of The Nurses Station	2006	1,600		20	160	160	573	10
11	Awning System Repairs	2006	1,500		20	150	150	525	11
12	Awning System Repairs	2006	2,250		20	225	225	788	12
13	Pipes And Wall Sealing Work	2006	2,000		20	200	200	700	13
14	Signage And Receptacles	2006	2,824		20	282	282	941	14
15	Valves For Refrigeration System	2006	966		20	97	97	314	15
16	2 Magnetic Door Holders	2006	1,775		20	178	178	651	16
17	Wall Mural	2006	750		20	75	75	244	17
18	Wall Mural	2006	750		20	75	75	244	18
19	Flooring	2006	2,000		20	133	133	422	19
20	Flooring	2006	769		20	51	51	162	20
21	20 Amp 120 Volt Circuit & Outlet For 2 New Pa Amplifiers	2006	1,875		20	188	188	594	21
22	Hinges & Align 4 Doors	2007	3,384		20	338	338	1,015	22
23	Hydrocollator	2007	2,500		20	250	250	750	23
24	Outlet For Stove In Therapy Room	2007	1,250		20	125	125	375	24
25	Double Pre-Hung Doors	2007	942		20	94	94	275	25
26	Painted Elevator Hallway	2007	1,675		20	168	168	489	26
27	Painted Elevator Hallway	2007	1,675		20	168	168	475	27
28	Kitchen Cabinets	2007	2,500		20	250	250	750	28
29	Drywall	2007	2,225		20	223	223	668	29
30	Wall Openings	2007	2,250		20	225	225	656	30
31	Shaw Rambler Rug	2007	478		20	48	48	135	31
32	Armstrong/Congoleum/Adhesive Vinly Title	2007	1,374		20	137	137	389	32
33	Winpak Software Upgrade	2007	7,752		20	775	775	2,326	33
34	TOTAL (lines 1 thru 33)		\$ 722,009	\$ 172,170		\$ 49,033	\$ (123,137)	\$ 373,081	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 722,009	\$ 172,170		\$ 49,033	\$ (123,137)	\$ 373,081	1
2	Cabinets - Dining Rooms	2007	9,600		20	960	960	2,800	2
3	Vct Tiles	2007	2,920		20	292	292	803	3
4	Carpeting	2007	2,200		20	220	220	605	4
5	Volt Circuit	2007	1,200		20	120	120	340	5
6	Wall And Flooring	2007	1,800		20	180	180	495	6
7	Wall Covering	2007	2,022		20	202	202	556	7
8	Wall Paper	2007	3,960		20	396	396	1,056	8
9	Wall Paper	2007	3,360		20	336	336	896	9
10	Vct Tile	2007	2,148		20	215	215	573	10
11	Vct Title	2007	2,838		20	284	284	757	11
12	Wallcoverings	2007	2,780		20	278	278	741	12
13	Circuit For Portable Heater	2007	1,600		20	160	160	427	13
14	Elevator Repairing	2007	4,218		20	422	422	1,265	14
15	Furnace	2007	3,885		20	389	389	1,101	15
16	Fantagraph Pleated Shades And Accessories	2007	3,504		20	350	350	905	16
17	Fantagraph Pleated Shades And Accessories	2007	1,426		20	143	143	404	17
18	Fantagraph Pleated Shades And Accessories	2007	1,383		20	138	138	380	18
19	Wiring And Fixture For Complete Electrical System For Sign Illu	2007	2,900		20	290	290	749	19
20	Crown Molding	2007	2,137		20	214	214	534	20
21	Mural Design For Dementia Unit	2007	2,400		20	240	240	600	21
22	Conduit Wire For 50A Range Receptacle For Physical Therapy R	2007	1,850		20	185	185	463	22
23	Valance & Controls Size	2007	5,409		20	541	541	1,262	23
24	Roof Sign Lighting Project	2007	2,950		20	295	295	688	24
25	Wood Cabinets	2007	6,380		20	638	638	1,648	25
26	Reface Nursing Stations	2007	3,980		20	398	398	929	26
27	Arbour Faux 2' Wood Blind	2007	171		20	17	17	40	27
28	Arbour Faux Wood Blinds	2007	1,262		20	126	126	284	28
29	Arbour Faux Wood Blinds	2007	6,038		20	604	604	1,308	29
30	Furnish/Install Lake Forest Wood Blind	2007	175		20	18	18	42	30
31	Furnish/Install Main Card Reader Panel Replacement	2007	4,100		20	410	410	1,093	31
32	Built-In Binty Sop Cabinets Laminate	2007	2,450		20	245	245	510	32
33	Furnish & Install Door Closer & Panic Device	2008	2,741		20	274	274	548	33
34	TOTAL (lines 1 thru 33)		\$ 817,796	\$ 172,170		\$ 58,613	\$ (113,557)	\$ 397,883	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 817,796	\$ 172,170		\$ 58,613	\$ (113,557)	\$ 397,883	1
2	Commerical Carpet	2008	798		20	80	80	160	2
3	Mural For Dementia Unit	2008	650		20	65	65	125	3
4	Plumbing Work	2008	2,523		20	252	252	505	4
5	Parking Lot Patching	2008	1,332		20	133	133	233	5
6	Remove & Replace Existing Asphalt Surface Of Parking Lot	2008	2,100		20	210	210	350	6
7	Furnish & Install Outside Video Cameras	2008	2,195		20	220	220	348	7
8	Custom Made Shaped Cornice Box	2008	1,961		20	196	196	327	8
9	Western Red Cedar Fencing With Gate	2008	9,500		20	950	950	1,425	9
10	Security Cameras	2008	1,235		20	124	124	196	10
11	Furnish & Install Fixtures	2008	3,850		20	385	385	545	11
12	Motor Assembly For Air Conditioner	2008	2,351		20	196	196	392	12
13	Cubicle Curtains, White Mesh With Tape On Top	2008	3,604		20	721	721	1,081	13
14	Air Supply Duct	2008	1,300		20	130	130	152	14
15	6 Custom Glass And Wood Partitions	2008	7,200		20	720	720	900	15
16	Counter Tops, Faucets, Baskets, And Hardware	2008	6,121		20	408	408	544	16
17	Light Fixtures And Larger Breaker For Floor Buffers	2008	2,950		20	295	295	393	17
18	New Awning System	2008	1,490		20	149	149	186	18
19	Resurface Doors - 1St & 2Nd Floor	2008	2,700		20	135	135	236	19
20	Voice Data & Fax Cables - Labor & Materials	2008	3,821		20	191	191	382	20
21	Carpet In Front 4 Offices	2009	2,510		20	359	359	359	21
22	Wallcoverings And Repainting Door Frames And Doors	2009	5,285		20	185	185	185	22
23	Front Desk Canopy	2009	2,800		20	257	257	257	23
24	Exhaust System	2009	2,800		20	233	233	233	24
25	Patching Walls And Hanging Wallpaper	2009	4,900		20	408	408	408	25
26	Patching Walls And Hanging Wallpaper	2009	4,200		20	315	315	315	26
27	Fire Alarm Door Holders	2009	2,500		20	146	146	146	27
28	Patio Electrical Work	2009	3,120		20	156	156	156	28
29	Fabricating Elevator Side Panels	2009	2,550		20	128	128	128	29
30	Refinishing Roof To Eliminate Standing Water	2009	4,375		20	146	146	146	30
31	Replacing Concrete Patio Slab	2009	2,850		20	71	71	71	31
32	Regal Cherry Techno Flooring	2009	4,370		20	73	73	73	32
33	Tadiran Ip X 500 Telephone System	2009	24,425		20	1,425	1,425	1,425	33
34	TOTAL (lines 1 thru 33)		\$ 942,162	\$ 172,170		\$ 68,075	\$ (104,095)	\$ 410,265	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 942,162	\$ 172,170		\$ 68,075	\$ (104,095)	\$ 410,265	1
2	2009	24,425		20	1,221	1,221	1,221	2
3	2009	3,751		20	402	402	402	3
4	2009	6,075		20	152	152	152	4
5	2009	10,700		20	178	178	178	5
6	2009	6,535		20	27	27	27	6
7	2009	3,500		20	29	29	29	7
8	2009	2,597		20	130	130	130	8
9	2009	2,730		20	137	137	137	9
10	2009	2,770		20	139	139	139	10
11	2009	2,582		20	129	129	129	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		\$ 1,007,827	\$ 172,170		\$ 70,618	\$ (101,552)	\$ 412,808	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue, LLC	2004	72,601	1,862	35	2,736	874	12,705	3
4	Allocated from Clinical Consulting	2004	4,033	103	35	115	12	706	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Nucare Services Corp.	2003	656	22	20	33	11	201	9
10	Allocated from Nucare Services Corp.	2004	13,322	444	20	667	223	3,808	10
11	Allocated from Nucare Services Corp.	2005	790	26	20	40	14	192	11
12	Allocated from Nucare Services Corp.	2006	1,071	36	20	54	18	180	12
13	Allocated from Nucare Services Corp.	2008	1,129	38	20	74	36	71	13
14	Allocated from Nucare Services Corp.	2009	397	13	20	7	(6)	7	14
15									15
16	Allocated from 7257 N. Lincoln Avenue, LLC	2005	6,618	524	20	427	(97)	1,841	16
17	Allocated from 7257 N. Lincoln Avenue, LLC	2004	1,443	83	20	72	(11)	397	17
18									18
19	Allocated from Clinical Consulting	2005	368	29	20	24	(5)	102	19
20	Allocated from Clinical Consulting	2004	80	5	20	4	(1)	22	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 102,508	\$ 3,185		\$ 4,253	\$ 1,068	\$ 20,232	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 832,497	\$ 2,703	\$ 106,572	\$ 103,869	10	\$ 569,720	71
72	Current Year Purchases	50,890	1,122	7,757	6,635	10	7,757	72
73	Fully Depreciated Assets	369,084		431	431	10	369,084	73
74								74
75	TOTALS	\$ 1,252,471	\$ 3,825	\$ 114,760	\$ 110,935		\$ 946,561	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	\$ 9,706	76
77										77
78										78
79										79
80	TOTALS			\$ 11,532	\$	\$ 1,153	\$ 1,153		\$ 9,706	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)	\$ 2,280,345	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,995	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,531	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,536	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,369,075	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$ <u>1,419,281</u>			3
4	Additions						4
5	<u>Storage Rental</u>			<u>3,965</u>			5
6	<u>Alloc. From NuCare</u>			<u>344</u>			6
7	TOTAL			\$ <u>1,423,590</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 27,070 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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 335,203	\$				\$	335,203	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					239,222		4,011				243,233	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 01	hrs		3,998			449,179						453,177	4	
5	Physician Care		visits												5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy	39 - 02	# of prescrpts							428,535				428,535	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify): See Supplemental				9,260			65,755		148,241				223,256	13	
14	TOTAL			\$	13,258			\$ 1,089,359	\$	580,787			\$	1,683,404	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,458	\$	1
2	Cash-Patient Deposits	6,499		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,226,781		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,577		6
7	Other Prepaid Expenses	170,131		7
8	Accounts Receivable (owners or related parties)	88,652		8
9	Other(specify): See Attached Schedule	530,409		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,132,507	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,207,844		15
16	Equipment, at Historical Cost	1,229,205		16
17	Accumulated Depreciation (book methods)	(1,682,628)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,166		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,166)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	10,976		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 765,397	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,897,904	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,147,222	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	572,048		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,121		31
32	Accrued Real Estate Taxes(Sch.IX-B)	586,657		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(37,967)		35
Other Current Liabilities(specify):				
36	See Attached Schedule	470,754		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,754,835	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,962,202		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,962,202	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,717,037	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,819,133)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,897,904	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,738,041)	1
2	Restatements (describe):		2
3	Additional Bad Debts	(325,000)	3
4	Medicare Bad Debts	(1,263)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,064,304)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(754,829)	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)	\$ (754,829)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (5,819,133)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,710,808	1
2	Discounts and Allowances for all Levels	(1,390,733)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,320,075	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,269,675	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,269,675	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,018,268	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,542	19
20	Radiology and X-Ray	17,824	20
21	Other Medical Services	176,948	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,238,582	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29,334	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,334	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	8,869	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,869	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,866,535	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,765,297	31
32	Health Care	4,545,654	32
33	General Administration	2,808,350	33
B. Capital Expense			
34	Ownership	2,609,666	34
C. Ancillary Expense			
35	Special Cost Centers	1,789,467	35
36	Provider Participation Fee	102,930	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,621,364	40
41	Income before Income Taxes (line 30 minus line 40)**	(754,829)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (754,829)	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:

01/01/09

Ending:

12/31/09

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	1,885	2,422	\$ 114,690	\$ 47.35	1
2	Assistant Director of Nursing	1,695	1,766	72,038	40.79	2
3	Registered Nurses	35,865	40,392	1,144,863	28.34	3
4	Licensed Practical Nurses	38,013	41,682	1,090,183	26.15	4
5	CNAs & Orderlies	108,530	118,161	1,205,273	10.20	5
6	CNA Trainees					6
7	Licensed Therapist	153	153	13,258	86.65	7
8	Rehab/Therapy Aides	9,124	9,632	158,850	16.49	8
9	Activity Director	3,753	4,171	78,437	18.81	9
10	Activity Assistants	11,015	12,287	119,626	9.74	10
11	Social Service Workers	3,039	3,656	136,178	37.25	11
12	Dietician	1,845	2,070	54,298	26.23	12
13	Food Service Supervisor					13
14	Head Cook	5,548	6,163	73,344	11.90	14
15	Cook Helpers/Assistants	20,167	22,851	224,604	9.83	15
16	Dishwashers					16
17	Maintenance Workers	3,960	4,299	91,469	21.28	17
18	Housekeepers	26,688	29,450	342,514	11.63	18
19	Laundry					19
20	Administrator	1,981	2,086	104,164	49.93	20
21	Assistant Administrator					21
22	Other Administrative	284	284	17,291	60.88	22
23	Office Manager					23
24	Clerical	9,216	10,150	210,965	20.78	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	1,980	2,162	42,181	19.51	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,798	4,466	78,146	17.50	33
34	TOTAL (lines 1 - 33)	288,539	318,303	\$ 5,372,372 *	\$ 16.88	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	746	\$ 19,618	01-03	35
36	Medical Director	Monthly	29,621	09-03	36
37	Medical Records Consultant	Monthly	5,324	10-03	37
38	Nurse Consultant	380	9,535	10-03	38
39	Pharmacist Consultant	Monthly	5,030	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	107	5,992	11-03	44
45	Social Service Consultant	78	4,340	12-03	45
46	Other(specify)				46
47	Medical Consultant	Monthly	14,800	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,311	\$ 94,260		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
John Stare	Administrator	0	\$ 104,164	Workers' Compensation Insurance	\$ 162,084	IDPH License Fee	\$	
Kathleen Brander	Dir of Reg Mgmt	0	5,348	Unemployment Compensation Insurance	54,699	Advertising: Employee Recruitment	7,092	
Marilyn Flaherty	VP of MC Reimb	0	11,943	FICA Taxes	377,986	Health Care Worker Background Check		
				Employee Health Insurance	321,794	(Indicate # of checks performed 384)	3,840	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues -ICLTC	13,697	
				Union Pension	26,037	Dues & Subscriptions	3,558	
				Dental Insurance	11,338	Licenses & Inspection	7,727	
				401K Matching Expense	4,927	Allocated from NuCare	757	
				Other Employee Benefits	51,418	See Supplemental Schedule	97	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 1,010,283	\$ 36,768		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
NuCare - Administrative Fees							Out-of-State Travel	
\$ 92,290							\$	
Clinical Conslt. Services - Administrative Fees								
10,225								
JLR - Management Fees							In-State Travel	
17,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 119,515				\$			13,667	
							Allocated from NuCare	
							475	
							Allocated from Clinical Consulting	
							120	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	
\$ 155,541				\$			\$ 14,262	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 - \$13,697
- (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. \$ 42,535 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N.A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 102,930
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? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.