

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/6/10

	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)	198	69,790	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	198	69,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			13,512	13,512	8
9	SNF/PED					9
10	ICF	46,145	3,714		49,859	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,145	3,714	13,512	63,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.80%

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 06/30/1997

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 198 and days of care provided 8,606

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	345,824	84,292	17,900	448,016		448,016		448,016		1
2	Food Purchase		330,050		330,050		330,050	(232)	329,818		2
3	Housekeeping	363,041	63,342	3,150	429,533		429,533		429,533		3
4	Laundry		27,490	9,984	37,474		37,474		37,474		4
5	Heat and Other Utilities			208,611	208,611		208,611	(5,886)	202,725		5
6	Maintenance	86,711	92,779	165,217	344,707		344,707	20,812	365,519		6
7	Other (specify):*										7
8	TOTAL General Services	795,576	597,953	404,862	1,798,391		1,798,391	14,694	1,813,085		8
	B. Health Care and Programs										
9	Medical Director			48,829	48,829		48,829		48,829		9
10	Nursing and Medical Records	3,812,978	330,987	33,638	4,177,603		4,177,603	(405)	4,177,198		10
10a	Therapy	185,042			185,042		185,042		185,042		10a
11	Activities	121,683	38,052	5,736	165,471		165,471	(24,303)	141,168		11
12	Social Services	90,194		5,366	95,560		95,560		95,560		12
13	CNA Training										13
14	Program Transportation			3,506	3,506		3,506		3,506		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,209,897	369,039	97,075	4,676,011		4,676,011	(24,708)	4,651,303		16
	C. General Administration										
17	Administrative	115,403		117,996	233,399		233,399	(90,469)	142,930		17
18	Directors Fees										18
19	Professional Services			140,665	140,665	(8,716)	131,949	(13,688)	118,260		19
20	Dues, Fees, Subscriptions & Promotions			128,610	128,610		128,610	(92,501)	36,109		20
21	Clerical & General Office Expenses	234,292	49,882	212,149	496,323		496,323	(23,708)	472,615		21
22	Employee Benefits & Payroll Taxes			946,361	946,361		946,361		946,361		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,253	13,253		13,253	539	13,792		24
25	Other Admin. Staff Transportation			1,283	1,283		1,283	1,173	2,456		25
26	Insurance-Prop.Liab.Malpractice			485,305	485,305		485,305	1,387	486,692		26
27	Other (specify):*							37,203	37,203		27
28	TOTAL General Administration	349,695	49,882	2,045,622	2,445,199	(8,716)	2,436,483	(180,066)	2,256,416		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,355,168	1,016,874	2,547,559	8,919,601	(8,716)	8,910,885	(190,080)	8,720,805		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:

01/01/10

Ending:

12/31/10

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			187,987	187,987		187,987	10,945	198,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			530,138	530,138		530,138	(54,674)	475,464			32
33	Real Estate Taxes			713,081	713,081	8,716	721,797	5,963	727,760			33
34	Rent-Facility & Grounds			1,470,953	1,470,953		1,470,953	271	1,471,224			34
35	Rent-Equipment & Vehicles			25,674	25,674		25,674	3,695	29,369			35
36	Other (specify):*											36
37	TOTAL Ownership			2,927,833	2,927,833	8,716	2,936,549	(33,800)	2,902,750			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	33,558	518,694	903,185	1,455,437		1,455,437		1,455,437			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,310	104,310		104,310	375	104,685			42
43	Other (specify):*	79,402		34,018	113,420		113,420	(113,420)				43
44	TOTAL Special Cost Centers	112,960	518,694	1,041,513	1,673,167		1,673,167	(113,045)	1,560,122			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,468,128	1,535,568	6,516,905	13,520,601		13,520,601	(336,925)	13,183,676			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:

01/01/10

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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	(8,062)	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	4,166	30		9
10	Interest and Other Investment Income	(57,902)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(193)	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	(12,991)	21		18
19	Entertainment	(1,517)	21		19
20	Contributions	(30,643)	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	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(56,328)	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	(222,318)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (505,789)		\$	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)	168,864		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 168,864		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (336,925)		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	52

SEE ACCOUNTANTS' COMPILATION REPORT

Renaissance at Hillside

ID# 0042176

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (86)	10	1
2	Veteran Expenses	(112)	10	2
3	Patient Needs	(6,102)	11	3
4	G&A Guest Relations	(76,752)	43	4
5	Patient Clothing	(18,201)	11	5
6	Bank Charges	(16,552)	21	6
7	Records Copies	(27,321)	21	7
8	Capitalized R&M	(13,292)	06	8
9	Out of State Seminars	(470)	24	9
10	Annual Reports	(375)	20	10
11	COPE Dues	(6,314)	20	11
12	Non-Allowable Legal Fees	(22,614)	19	12
13	Marketing Services	(22,018)	43	13
14	Non-Allowable Office Expense	(12,000)	43	14
15	Bed Tax	375	42	15
16	Marketing Travel	(7)	25	16
17	Additional R&M	28,802	06	17
18	Marketing Seminar	(100)	24	18
19	Legal Fees Refund	(10)	19	19
20	Phone Income	(1,396)	21	20
21	Food Rebate	(39)	02	21
22	Medical Supplies Refund	(25,085)	10	22
23	Marketing Salary	(2,650)	43	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	(222,318)		49

Renaissance at Hillside

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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:

01/01/10

Ending:

12/31/10

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	(232)											(232)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,062)		2,176									(5,886)	5
6	Maintenance	15,510		5,302									20,812	6
7	Other (specify):*													7
8	TOTAL General Services	7,216		7,478									14,694	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25,283)				24,878							(405)	10
10a	Therapy													10a
11	Activities	(24,303)											(24,303)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(49,586)				24,878							(24,708)	16
	C. General Administration													
17	Administrative			(84,217)	4,554	(8,065)	(2,741)						(90,469)	17
18	Directors Fees													18
19	Professional Services	(22,624)		8,445		28	463						(13,688)	19
20	Fees, Subscriptions & Promotions	(93,660)		1,131		28							(92,501)	20
21	Clerical & General Office Expenses	(179,777)		134,455		20,456	1,157						(23,708)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(570)		968		141							539	24
25	Other Admin. Staff Transportation	(7)		985		195							1,173	25
26	Insurance-Prop.Liab.Malpractice			1,387									1,387	26
27	Other (specify):*			29,910	184	6,287	822						37,203	27
28	TOTAL General Administration	(296,638)		93,063	4,738	19,070	(299)						(180,066)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(339,008)		100,541	4,738	43,948	(299)						(190,080)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	4,166		6,658		121							10,945	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(57,902)		3,058		170							(54,674)	32
33	Real Estate Taxes			5,963									5,963	33
34	Rent-Facility & Grounds			271									271	34
35	Rent-Equipment & Vehicles			3,695									3,695	35
36	Other (specify):*													36
37	TOTAL Ownership	(53,736)		19,645		291							(33,800)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	375											375	42
43	Other (specify):*	(113,420)											(113,420)	43
44	TOTAL Special Cost Centers	(113,045)											(113,045)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(505,789)		120,186	4,738	44,239	(299)						(336,925)	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	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,176	\$	2,176	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	5,302		5,302	16
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	13,714		13,714	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	8,445		8,445	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,131		1,131	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	134,455		134,455	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	968		968	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	985		985	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,387		1,387	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	29,910		29,910	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	6,658		6,658	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,058		3,058	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	5,963		5,963	27
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	271		271	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,695		3,695	29
30	V								30
31	V	17 ADMINISTRATIVE FEES	97,931	NUCARE SERVICES CORP.	100.00%			(97,931)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 97,931			\$ 218,117	\$ *	120,186	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	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	4,554	\$	4,554	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	184		184	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		\$			4,738	\$ *	4,738	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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 24,878	\$	24,878	15
16	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	28		28	16
17	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	28		28	17
18	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	18,175		18,175	18
19	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,281		2,281	19
20	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	141		141	20
21	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	195		195	21
22	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,961		2,961	22
23	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,326		3,326	23
24	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	121		121	24
25	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	170		170	25
26	V								26
27	V	17 ADINISTRATIVE FEES	8,065	CLINICAL CONSULTING SERVICES, LLC	100.00%			(8,065)	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		\$ 8,065			\$ 52,304	\$ *	44,239	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	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				822		822	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	17 MANAGEMENT FEES	12,000					(12,000)	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		\$ 12,000			\$ 11,701	\$ *	(299)	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:	
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: 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.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Jack Rajchenbach	Relative	Administrative	0	See Attached	5	7.69%	Alloc. Salary	\$ 9,259	17-7	1
2	Robert Hartman	Relative	Administrative	0	See Attached	1.14	2.28%	Alloc. Salary	4,554	17-7	2
3	David Hartman	Relative	Administrative	0	See Attached	0.68	1.70%				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by										11
12	the IL Dept of HFS										12
13								TOTAL	\$ 13,813		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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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	1,226,110	16	\$ 38,227	\$ 69,790	\$ 2,176	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156	69,790	5,302	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	13,714	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362	69,790	8,445	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864	69,790	1,131	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	134,455	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998	69,790	968	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306	69,790	985	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362	69,790	1,387	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475	69,790	29,910	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967	69,790	6,658	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729	69,790	3,058	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761	69,790	5,963	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765	69,790	271	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914	69,790	3,695	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,832,004	\$ 2,265,297	\$ 218,117	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	1	4,554	1
2									2
3									3
4									4
5									5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234	1	184	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					\$ 83,234	\$ 80,000	\$ 4,738	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	1,226,110	16	\$ 437,066	\$ 437,066	69,790	24,878	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484	69,790	28	2	
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	1,226,110	16	488	69,790	28	3	
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	69,790	18,175	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077	69,790	2,281	5	
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	1,226,110	16	2,480	69,790	141	6	
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430	69,790	195	7	
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028	69,790	2,961	8	
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440	69,790	3,326	9	
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132	69,790	121	10	
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985	69,790	170	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					\$ 918,910	\$ 756,366	\$ 52,304	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/10

Ending: 12/31/10

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 54.00	9	\$ 100,000	\$ 100,000	5.00	\$ 9,259	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 54.00	9	5,000		5.00	463	2
3	21	OFFICE	AVG. HOURS WORKED 54.00	9	12,497	12,497	5.00	1,157	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED 54.00	9	8,881		5.00	822	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				\$ 126,378	\$ 112,497		\$ 11,701	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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: 01/01/10 Ending: 12/31/10

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:

01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		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	Shareholders Loan		X							\$ 439,579	1							
2											2							
3											3							
4											4							
5	See Supplemental Schedule										5							
Working Capital																		
6	Sun Joint Venture		X							60,373	6							
7	Hillside Ltd. Partnership		X							30,186	7							
8	See Supplemental Schedule									3,228	8							
9	TOTAL Facility Related					\$	\$			\$ 533,366	9							
B. Non-Facility Related*																		
10	Interest Income		X							(57,902)	10							
11											11							
12											12							
13	See Supplemental Schedule										13							
14	TOTAL Non-Facility Related					\$	\$			\$ (57,902)	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 475,464	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:

01/01/10

Ending:

12/31/10

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	Allocated from NuCare		X							3,058										
9	Allocated from Clinical Consulting		X							170										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									3,228										
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.)

2009 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 2009 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 2009.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>15-17-101-14-0000</u>	<u>Long Term Care Property</u>	\$ <u>695,013.12</u>	\$ <u>695,013.12</u>
2.	<u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>81,288.74</u>	\$ <u>4,395.43</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>776,301.86</u></u>	\$ <u><u>699,408.55</u></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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.**

Facility Name & ID Number Renaissance at Hillside

0042176 Report Period Beginning:

01/01/10 Ending:

12/31/10

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 7257 N. Lincoln</u>		<u>2004</u>	<u>\$ 8,196</u>	<u>1</u>
2	<u>Allocated from Clinical Consulting</u>		<u>2004</u>	<u>455</u>	<u>2</u>
3	TOTALS			\$ 8,651	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	8,679	9
10	Various		1998	40,341		20	2,017	2,017	25,262	10
11	Various		1999	52,100		20	2,605	2,605	30,206	11
12	Various		2000	30,099		20	2,179	2,179	36,174	12
13	Various		2001	49,889		20	2,494	2,494	24,085	13
14	Various		2002	123,175		20	8,891	8,891	109,989	14
15	Various		2003	10,905		20	1,091	1,091	8,247	15
16	Various		2004	21,754		20	2,504	2,504	16,730	16
17	Various		2005	201,638		20	14,715	14,715	106,724	17
18	Various		2006	48,604		20	4,344	4,344	19,935	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								67
68			164,716	5,156	6,600	1,444	27,879	68
69				187,987		(187,987)		69
70		\$	756,211	\$	48,091	\$	413,910	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:

01/01/10

Ending:

12/31/10

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		\$ 756,211	\$ 193,143		\$ 48,091	\$ (145,052)	\$ 413,910	1
2	Hinges & Align 4 Doors	2007	3,384		20	338	338	1,354	2
3	Hydrocollator	2007	2,500		20	250	250	1,000	3
4	Outlet For Stove In Therapy Room	2007	1,250		20	125	125	500	4
5	Double Pre-Hung Doors	2007	942		20	94	94	369	5
6	Painted Elevator Hallway	2007	1,675		20	168	168	656	6
7	Painted Elevator Hallway	2007	1,675		20	168	168	642	7
8	Kitchen Cabinets	2007	2,500		20	250	250	1,000	8
9	Drywall	2007	2,225		20	223	223	890	9
10	Wall Openings	2007	2,250		20	225	225	881	10
11	Shaw Rambler Rug	2007	478		20	48	48	183	11
12	Armstrong/Congoleum/Adhesive Vinly Title	2007	1,374		20	137	137	527	12
13	Winpak Software Upgrade	2007	7,752		20	775	775	3,101	13
14	Cabinets - Dinning Rooms	2007	9,600		20	960	960	3,760	14
15	Vct Tiles	2007	2,920		20	292	292	1,095	15
16	Carpeting	2007	2,200		20	220	220	825	16
17	Volt Circuit	2007	1,200		20	120	120	460	17
18	Wall And Flooring	2007	1,800		20	180	180	675	18
19	Wall Covering	2007	2,022		20	202	202	758	19
20	Wall Paper	2007	3,960		20	396	396	1,452	20
21	Wall Paper	2007	3,360		20	336	336	1,232	21
22	Vct Tile	2007	2,148		20	215	215	788	22
23	Vct Title	2007	2,838		20	284	284	1,041	23
24	Wallcoverings	2007	2,780		20	278	278	1,019	24
25	Circuit For Portable Heater	2007	1,600		20	160	160	587	25
26	Elevator Repairing	2007	4,218		20	422	422	1,687	26
27	Furnace	2007	3,885		20	389	389	1,489	27
28	Fantagraph Pleated Shades And Accessories	2007	3,504		20	350	350	1,256	28
29	Fantagraph Pleated Shades And Accessories	2007	1,426		20	143	143	547	29
30	Fantagraph Pleated Shades And Accessories	2007	1,383		20	138	138	519	30
31	Wiring And Fixture For Complete Electrical System For Sign Illu	2007	2,900		20	290	290	1,039	31
32	Crown Molding	2007	2,137		20	214	214	748	32
33	Mural Design For Dementia Unit	2007	2,400		20	240	240	840	33
34	TOTAL (lines 1 thru 33)		\$ 842,498	\$ 193,143		\$ 56,720	\$ (136,423)	\$ 446,829	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:

01/01/10

Ending:

12/31/10

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		\$ 842,498	\$ 193,143		\$ 56,720	\$ (136,423)	\$ 446,829	1
2	Conduit Wire For 50A Range Receptacle For Physical Therapy R	2007	1,850		20	185	185	648	2
3	Valance & Controls Size	2007	5,409		20	541	541	1,803	3
4	Roof Sign Lighting Project	2007	2,950		20	295	295	983	4
5	Wood Cabinets	2007	6,380		20	638	638	2,286	5
6	Reface Nursing Stations	2007	3,980		20	398	398	1,327	6
7	Arbour Faux 2' Wood Blind	2007	171		20	17	17	57	7
8	Arbour Faux Wood Blinds	2007	1,262		20	126	126	410	8
9	Arbour Faux Wood Blinds	2007	6,038		20	604	604	1,912	9
10	Furnish/Install Lake Forest Wood Blind	2007	175		20	18	18	60	10
11	Furnish/Install Main Card Reader Panel Replacement	2007	4,100		20	410	410	1,503	11
12	Built-In Bintv Sop Cabinets Laminate	2007	2,450		20	245	245	755	12
13	Furnish & Install Door Closer & Panic Device	2008	2,741		20	274	274	822	13
14	Commerical Carpet	2008	798		20	80	80	239	14
15	Mural For Dementia Unit	2008	650		20	65	65	190	15
16	Plumbing Work	2008	2,523		20	252	252	757	16
17	Parking Lot Patching	2008	1,332		20	133	133	366	17
18	Remove & Replace Existing Asphalt Surface Of Parking Lot	2008	2,100		20	210	210	560	18
19	Furnish & Install Outside Video Cameras	2008	2,195		20	220	220	567	19
20	Custom Made Shaped Cornice Box	2008	1,961		20	196	196	523	20
21	Western Red Cedar Fencing With Gate	2008	9,500		20	950	950	2,375	21
22	Security Cameras	2008	1,235		20	124	124	319	22
23	Furnish & Install Fixtures	2008	3,850		20	385	385	930	23
24	Motor Assembly For Air Conditoner	2008	2,351		20	196	196	588	24
25	Cubicle Curtains, White Mesh With Tape On Top	2008	3,604		20	721	721	1,802	25
26	Air Supply Duct	2008	1,300		20	130	130	282	26
27	6 Custom Glass And Wood Partitions	2008	7,200		20	720	720	1,620	27
28	Counter Tops, Faucets, Baskets, And Hardware	2008	6,121		20	408	408	952	28
29	Light Fixtures And Larger Breaker For Floor Buffers	2008	2,950		20	295	295	688	29
30	New Awning System	2008	1,490		20	149	149	335	30
31	Resurface Door - 1St & 2Nd Floors	2008	2,700		20	135	135	371	31
32	Voice Data & Fax Cables - Labor & Materials	2008	3,821		20	191	191	573	32
33	Carpet In Front 4 Offices	2009	2,510		20	359	359	717	33
34	TOTAL (lines 1 thru 33)		\$ 940,194	\$ 193,143		\$ 66,388	\$ (126,755)	\$ 474,151	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:

01/01/10

Ending:

12/31/10

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		\$ 940,194	\$ 193,143		\$ 66,388	\$ (126,755)	\$ 474,151	1
2	Wallcoverings And Repainting Door Frames And Doors	2009	5,285		20	1,057	1,057	2,114	2
3	Front Desk Canopy	2009	2,800		20	280	280	537	3
4	Exhaust System	2009	2,800		20	280	280	513	4
5	Patching Walls And Hanging Wallpaper	2009	4,900		20	490	490	898	5
6	Patching Walls And Hanging Wallpaper	2009	4,200		20	420	420	735	6
7	Fire Alarm Door Holders	2009	2,500		20	250	250	396	7
8	Patio Electrical Work	2009	3,120		20	312	312	468	8
9	Fabricating Elevator Side Panels	2009	2,550		20	255	255	383	9
10	Refinishing Roof To Eliminate Standing Water	2009	4,375		20	438	438	583	10
11	Replacing Concrete Patio Slab	2009	2,850		20	285	285	356	11
12	Regal Cherry Techno Flooring	2009	4,370		20	291	291	364	12
13	Tadiran Ip X 500 Telephone System	2009	24,425		20	2,443	2,443	3,867	13
14	Tadiran Ip X 500 Telephone System	2009	24,425		20	2,443	2,443	3,664	14
15	Wanderguard E. Standard System	2009	3,751		20	536	536	938	15
16	Refinish Roof	2009	6,075		20	608	608	759	16
17	Concrete, Brick, Foundation, And Sidewalk Work	2009	10,700		20	1,070	1,070	1,248	17
18	Paint And Wallpaper Work To Front Lobby	2009	6,537		20	1,307	1,307	1,525	18
19	3 Custom Coffeured Ceiling, Wood, And Acrylic	2009	3,500		20	350	350	379	19
20	Install Light Fixtures	2009	2,597		20	130	130	238	20
21	Change Locks & Electric Work	2009	2,730		20	137	137	250	21
22	Door Repair	2009	2,770		20	139	139	231	22
23	Electrical Work	2009	2,582		20	129	129	151	23
24	Wallcovering	2010	3,435		20	315	315	315	24
25	Emergency Back Up	2010	2,500		20	208	208	208	25
26	Remodeling-Dementia Unit-Wallpaper, Painting, Flooring	2010	6,600		20	550	550	550	26
27	Remodeling-Dementia Unit-Wallpaper, Painting, Flooring	2010	17,640		20	662	662	662	27
28	Dementia Remodeling-Wood Casing	2010	3,345		20	223	223	223	28
29	New Floor-Conf Rm & Nursing Station	2010	3,289		20	219	219	219	29
30	Awnings	2010	7,239		20	483	483	483	30
31	Sprinklers	2010	4,880		20	285	285	285	31
32	Dementia Unit-Wood Casings Balance	2010	6,690		20	446	446	446	32
33	New Floor-Conf Rm & Nursing Station- Balance	2010	3,289		20	192	192	192	33
34	TOTAL (lines 1 thru 33)		\$ 1,128,944	\$ 193,143		\$ 83,618	\$ (109,525)	\$ 498,331	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,128,944	\$ 193,143		\$ 83,618	\$ (109,525)	\$ 498,331	1
2	Renovate 10 Rooms-Custom Build Cabinet, Privacy Walls W/Slidi	2010	16,500		20	688	688	688	2
3	Cornice Board W/ Welting	2010	4,346		20	435	435	435	3
4	Asphalt Repairs	2010	5,785		20	579	579	579	4
5	Electricakl Renovations To Patient Room	2010	11,100		20	370	370	370	5
6	Install Dry Horizontal Sidewall Sprinklers	2010	4,880		20	163	163	163	6
7	Wallcovering For 5 Room Renovation	2010	5,200		20	130	130	130	7
8	Electrical Wiring To Install Wander Guard System	2010	2,925		20	49	49	49	8
9	South Wing Renovations-Walls Repairs, Painting	2010	6,600		20	110	110	110	9
10	Installation Of Wallpaper In 5 Rooms	2010	6,895		20	115	115	115	10
11	Install Dry Horizontal Sidewall Sprinklers	2010	4,881		20	81	81	81	11
12	West Wing Renovtions-Walls Repairs, Painting	2010	7,700		20	128	128	128	12
13	Remove Parking Posts And Redo Blacktop	2010	3,500		20	58	58	58	13
14	Repair Kitchen Fridge	2010	2,787		20	139	139	139	14
15	A/C Repair	2010	4,305		20	215	215	215	15
16	Hand Rail Night Lights	2010	3,600		20	180	180	180	16
17	Furnish & Install Door Alarms	2010	2,600		20	130	130	130	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)		\$ 1,222,548	\$ 193,143		\$ 87,187	\$ (105,956)	\$ 501,901	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.

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		73,768	1,891	35	2,108	217	15,017	3
4	Allocated from Clinical Consulting		4,098	105	35	117	12	834	4
5									5
6									6
7									7
8	Leasehold Improvements:	2003	667	24	20	33	9	237	8
9	Allocated from Nucare Services Corp.	2004	13,536	494	20	678	184	4,547	9
10	Allocated from Nucare Services Corp.	2005	803	29	20	40	11	235	10
11	Allocated from Nucare Services Corp.	2006	1,088	40	20	54	14	237	11
12	Allocated from Nucare Services Corp.	2008	1,147	42	20	57	15	129	12
13	Allocated from Nucare Services Corp.	2009	58,125	2,119	20	2,906	787	3,635	13
14	Allocated from Nucare Services Corp.	2010	2,838	103	20	72	(31)	72	14
15									15
16	Allocated from 7257 N. Lincoln Avenue, LLC	2005	6,725	293	20	434	141	2,305	16
17	Allocated from 7257 N. Lincoln Avenue, LLC	2004	1,466		20	73	73	477	17
18									18
19	Allocated from Clinical Consulting	2005	374	16	20	24	8	128	19
20	Allocated from Clinical Consulting	2004	81		20	4	4	26	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)		\$ 164,716	\$ 5,156		\$ 6,600	\$ 1,444	\$ 27,879	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	\$ 870,407	\$ 1,336	\$ 100,960	\$ 99,624	10	\$ 662,259	71
72	Current Year Purchases	65,382	267	9,344	9,077	10	9,344	72
73	Fully Depreciated Assets	382,935		243	243	10	382,935	73
74								74
75	TOTALS	\$ 1,318,724	\$ 1,603	\$ 110,548	\$ 108,945		\$ 1,054,537	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	\$ 10,859	76
77		Allocated from NuCare	2010	504	18	42	24	5	42	77
78										78
79										79
80	TOTALS			\$ 12,036	\$ 18	\$ 1,195	\$ 1,177		\$ 10,901	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)	\$ 2,561,959	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 194,764	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,930	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,166	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,567,339	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: _____

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>1,467,984</u>			3
4	Additions						4
5	Storage Rental			<u>2,969</u>			5
6	Allocated from NuCare			<u>271</u>			6
7	TOTAL			\$ <u>1,471,224</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: \$ 29,369 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. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 280,443	\$		\$ 280,443	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			237,610			237,610	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	23,172		335,338			358,510	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				435,471		435,471	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			10,386		49,794	83,223		143,403	13
14	TOTAL			\$ 33,558		\$ 903,185	\$ 518,694		\$ 1,455,437	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: 01/01/10

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,000	\$	1
2	Cash-Patient Deposits	7,957		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,634,338		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,952		6
7	Other Prepaid Expenses	474,670		7
8	Accounts Receivable (owners or related parties)	3,268,454		8
9	Other(specify): See Attached Schedule	239,785		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,759,156	\$	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	1,347,065		15
16	Equipment, at Historical Cost	1,317,270		16
17	Accumulated Depreciation (book methods)	(1,871,415)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	30,315		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 823,235	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,582,391	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,250,648	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	348,866		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,946		31
32	Accrued Real Estate Taxes(Sch.IX-B)	617,728		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	10,945,525		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,178,713	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,178,713	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,596,322)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,582,391	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,819,133)	1
2	Restatements (describe):		2
3	See Attached	(63,271)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,882,404)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(713,918)	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)	\$ (713,918)	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)	\$ (6,596,322)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	\$ 10,664,243	1
2	Discounts and Allowances for all Levels	(1,082,477)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,581,766	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,885,548	6
7	Oxygen	11,097	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,896,645	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	1,009,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	76,844	19
20	Radiology and X-Ray	23,633	20
21	Other Medical Services	133,142	21
22	Laundry	368	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,243,014	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	57,902	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,902	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	27,356	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,356	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,806,683	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,798,391	31
32	Health Care	4,676,011	32
33	General Administration	2,445,199	33
B. Capital Expense			
34	Ownership	2,927,833	34
C. Ancillary Expense			
35	Special Cost Centers	1,568,857	35
36	Provider Participation Fee	104,310	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,520,601	40
41	Income before Income Taxes (line 30 minus line 40)**	(713,918)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (713,918)	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:

01/01/10

Ending:

12/31/10

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	1,901	2,085	\$ 100,831	\$ 48.36	1
2	Assistant Director of Nursing	1,879	2,198	82,086	37.35	2
3	Registered Nurses	34,896	39,331	1,182,301	30.06	3
4	Licensed Practical Nurses	40,504	44,629	1,142,418	25.60	4
5	CNAs & Orderlies	109,700	119,851	1,262,858	10.54	5
6	CNA Trainees					6
7	Licensed Therapist	401	401	33,558	83.69	7
8	Rehab/Therapy Aides	10,370	10,948	185,042	16.90	8
9	Activity Director					9
10	Activity Assistants	11,404	12,592	121,683	9.66	10
11	Social Service Workers	2,757	3,118	90,194	28.93	11
12	Dietician	1,949	2,086	56,436	27.05	12
13	Food Service Supervisor					13
14	Head Cook	5,527	6,147	74,990	12.20	14
15	Cook Helpers/Assistants	18,782	21,298	214,398	10.07	15
16	Dishwashers					16
17	Maintenance Workers	3,467	4,047	86,711	21.43	17
18	Housekeepers	28,792	31,598	363,041	11.49	18
19	Laundry					19
20	Administrator	1,957	2,160	102,804	47.59	20
21	Assistant Administrator					21
22	Other Administrative	284	284	12,599	44.36	22
23	Office Manager	1,578	2,006	63,443	31.63	23
24	Clerical	7,932	9,167	170,849	18.64	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	1,946	2,124	42,484	20.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,722	4,362	79,402	18.20	33
34	TOTAL (lines 1 - 33)	289,748	320,432	\$ 5,468,128 *	\$ 17.06	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	658	\$ 17,900	01-03	35
36	Medical Director	Monthly	48,829	09-03	36
37	Medical Records Consultant	Monthly	2,471	10-03	37
38	Nurse Consultant	551	19,334	10-03	38
39	Pharmacist Consultant	Monthly	4,863	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	101	5,736	11-03	44
45	Social Service Consultant	94	5,366	12-03	45
46	Other(specify)				46
47	Medical Consultnt	Monthly	6,800	10-03	47
48	Wound Care Consult	Monthly	170	10-03	48
49	TOTAL (lines 35 - 48)	1,404	\$ 111,469		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	\$ 102,804	Workers' Compensation Insurance	\$ 35,894	IDPH License Fee	\$	
Kathleen Brander	Dir of Reg Mgmt	0	708	Unemployment Compensation Insurance	53,803	Advertising: Employee Recruitment	9,418	
Marilyn Flaherty	VP of MC Reimb	0	11,891	FICA Taxes	396,709	Health Care Worker Background Check		
				Employee Health Insurance	354,554	(Indicate # of checks performed 500)	5,000	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues - ICLTC	8,752	
				Union Pension	41,207	Dues & Subscriptions	5,463	
				Denatal Insurance	14,774	Licenses & Inspections	6,317	
				Other Employee Benefits	42,603	Allocated from NuCare	1,131	
				401K Matching Expense	6,817	See Supplemental Schedule	28	
						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)		
					\$ 115,403			
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	
\$ 97,931							\$	
Clinical Conslt. Services - Administrative Fees								
8,065								
JLR - Management Fees							In-State Travel	
12,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			Seminar Expense	
							12,683	
\$ 117,995							Allocated from Nucare	
							968	
C. Professional Services							Allocated from Clinical Consulting	
Vendor/Payee							141	
Type							Entertainment Expense	
Amount							()	
Frost, Ruttenberg & Rothblatt							(agree to Sch. V, line 24, col. 8)	
Accounting							\$ 13,792	
25,766								
See Attached								
Legal								
52,610								
Personnel Planners								
Unemployment Tax Conslt.								
3,360								
CDW Computer Centers								
Computer Serives								
5,554								
Emdeon Business Services								
Computer Serives								
786								
Giftrap								
Computer Serives								
6,737								
HDSI								
Computer Serives								
6,432								
MDI Achieves								
Computer Serives								
3,495								
PSD Solutions								
Computer Serives								
15,706								
Sonicwall Services								
Computer Serives								
292								
Symantec								
Computer Serives								
342								
See Supplemetal Schedule								
19,584								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 140,665								

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside

0042176

Report Period Beginning: 01/01/10

Ending: 12/31/10

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 - \$15,067
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 85 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. \$ 104,685
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% in 14
d. Have vehicle usage logs been maintained?
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?
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.