

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0042176 Facility Name: Renaissance At Hillside Address: 4600 Frontage Road Hillside 60162 County: Cook Telephone Number: (708) 544-9933 Fax #: (708) 544-9966 HFS ID Number: Date of Initial License for Current Owners: 06/30/97 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) Kimberley A. Waite, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance At Hillside

0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	198	Skilled (SNF)	198	72,270	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	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			9,415	9,415	8
9	SNF/PED					9
10	ICF	49,918	4,098	3,014	57,030	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,918	4,098	12,429	66,445	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.94%

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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 06/30/1997

J. Was the facility purchased or leased after January 1, 1978? YES X Date 06/30/1997 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 198 and days of care provided 7,759

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11
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	344,663	63,638	21,566	429,867		429,867		429,867			1
2	Food Purchase		347,107		347,107		347,107	(214)	346,893			2
3	Housekeeping	355,152	53,985	3,150	412,287		412,287		412,287			3
4	Laundry	11,583	53,368		64,951		64,951		64,951			4
5	Heat and Other Utilities			201,480	201,480		201,480	(5,485)	195,995			5
6	Maintenance	52,041	108,046	136,495	296,582		296,582	20,907	317,489			6
7	Other (specify):*											7
8	TOTAL General Services	763,439	626,144	362,691	1,752,274		1,752,274	15,208	1,767,482			8
	B. Health Care and Programs											
9	Medical Director			59,550	59,550		59,550		59,550			9
10	Nursing and Medical Records	3,782,736	739,639	21,213	4,543,588		4,543,588	(24,488)	4,519,100			10
10a	Therapy	166,024			166,024		166,024		166,024			10a
11	Activities	243,516	16,255	5,800	265,571		265,571		265,571			11
12	Social Services	157,652		2,813	160,465		160,465		160,465			12
13	CNA Training											13
14	Program Transportation			18,873	18,873		18,873		18,873			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,349,928	755,894	108,249	5,214,071		5,214,071	(24,488)	5,189,583			16
	C. General Administration											
17	Administrative	170,311		118,795	289,106		289,106	(96,766)	192,340			17
18	Directors Fees											18
19	Professional Services			159,757	159,757	(9,215)	150,542	358	150,899			19
20	Dues, Fees, Subscriptions & Promotions			116,570	116,570		116,570	(76,391)	40,179			20
21	Clerical & General Office Expenses	299,012	74,616	626,051	999,679		999,679	(407,258)	592,421			21
22	Employee Benefits & Payroll Taxes			1,033,992	1,033,992		1,033,992		1,033,992			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,242	25,242		25,242	(6,480)	18,762			24
25	Other Admin. Staff Transportation			3,929	3,929		3,929	826	4,755			25
26	Insurance-Prop.Liab.Malpractice			622,203	622,203		622,203	635	622,838			26
27	Other (specify):*							45,240	45,240			27
28	TOTAL General Administration	469,323	74,616	2,706,539	3,250,478	(9,215)	3,241,263	(539,837)	2,701,426			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,582,690	1,456,654	3,177,479	10,216,823	(9,215)	10,207,608	(549,116)	9,658,492			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.

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			193,106	193,106		193,106	2,769	195,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			586,337	586,337		586,337	179	586,516			32
33	Real Estate Taxes			333,456	333,456	9,215	342,671	6,842	349,513			33
34	Rent-Facility & Grounds			1,559,728	1,559,728		1,559,728	360	1,560,088			34
35	Rent-Equipment & Vehicles			17,271	17,271		17,271	2,824	20,095			35
36	Other (specify):*											36
37	TOTAL Ownership			2,689,898	2,689,898	9,215	2,699,113	12,975	2,712,088			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,062	420,180	819,524	1,245,766		1,245,766		1,245,766			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			378,745	378,745		378,745		378,745			42
43	Other (specify):*	152,936		36,684	189,620		189,620	(189,620)	(0)			43
44	TOTAL Special Cost Centers	158,998	420,180	1,234,953	1,814,131		1,814,131	(189,620)	1,624,511			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,741,688	1,876,834	7,102,330	14,720,852		14,720,852	(725,762)	13,995,090			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,523)	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	(4,666)	30		9
10	Interest and Other Investment Income	(2,136)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(214)	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	(12,385)	21		18
19	Entertainment	(6,906)	24		19
20	Contributions	(23,335)	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	(527,480)	21		24
25	Fund Raising, Advertising and Promotional	(49,578)	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	(254,136)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (888,359)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	162,597		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 162,597		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (725,762)		37

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

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

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

Renaissance At Hillside

	ID#	0042176
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Rental Income	\$ (69)	21	1
2	Non-Allowable Fees	(2,500)	43	2
3	Jury Duty Income	(86)	10	3
4	Patient Needs	(15,753)	10	4
5	Patient Clothing	(15,491)	10	5
6	Guest Relations	(47,640)	43	6
7	Bank Charges	(18,324)	21	7
8	Marketing Services	(22,184)	43	8
9	Non-Allowable Office Expense	(12,000)	43	9
10	Medical Records Revenue	(514)	21	10
11	Annual Reports	(225)	20	11
12	Out of Period and Non-Allowable Legal	(22,387)	19	12
13	Additional R&M	15,672	06	13
14	Capitzlized R&M	(3,101)	06	14
15	Non-Reimbursable Salaries	(105,296)	43	15
16	COPE Dues	(4,238)	20	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(254,136)		49

Renaissance At Hillside

	ID#	0042176
Report Period Beginning:		01/01/11
Ending:		12/31/11

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

Summary A

12/31/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

1		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)	
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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,038	\$	2,038 15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,103		8,103 16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	12,770		12,770 17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	22,282		22,282 18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	957		957 19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	135,660		135,660 20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	244		244 21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	568		568 22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	635		635 23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	42,968		42,968 24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	7,328		7,328 25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,194		2,194 26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,842		6,842 27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	360		360 28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,824		2,824 29
30	V								30
31	V	17	ADMINISTRATIVE FEES	98,669	NUCARE SERVICES CORP.	100.00%			(98,669) 31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 98,669			\$ 245,772	\$ *	147,103 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 234	\$ 234	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	6,842	6,842	16
17	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			17
18	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	28	28	18
19	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	13,260	13,260	19
20	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	894	894	20
21	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	182	182	21
22	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	258	258	22
23	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	69	69	23
24	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	798	798	24
25	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	107	107	25
26	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	122	122	26
27	V								27
28	V	17	ADINISTRATIVE FEES	8,126	CLINICAL CONSULTING SERVICES, LLC	100.00%		(8,126)	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			\$ 8,126			\$ 22,793	\$ * 14,667	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	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				1,700	1,700	17
18	V	27	EMPLOYEE BENEFITS				1,405	1,405	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	17	MANAGEMENT FEES	12,000	JLR MANAGEMENT CORP.	100.00%		(12,000)	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			\$ 12,000			\$ 12,827	\$ * 827	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 118,549	Diamond Insurance	40.00%	\$ 118,549	\$	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			\$ 118,549			\$ 118,549	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM J. STERN	4.900%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	1
2	BERNARD HOLLANDER FAMILY TRUST	25.000%	CALIFORNIA GARDENS CORP.	CHICAGO	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	2
3	EVAN MICHAEL STERN 2005 TRUST	0.900%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	DBD REHABILITAION SERV.	CHICAGO	PSYCHIATRIC SERVICE	3
4	JONATHAN BRYAN STERN 2001 TRUST	0.900%	CLARIDGE IMPERIAL, LTD.	CHICAGO	JEM REHABILITATION SERV.	CHICAGO	PSYCHIATRIC SERVICE	4
5	MARSHALL A. MAUER	6.250%	FOREST VILLA NURSING & REHABILITATION CENTER, L.L.C.	NILES	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	5
6	MAURICE I. AARON	4.250%	JACKSON CORP.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	6
7	ORA AARON	2.000%	MONROE CORP.	CHICAGO	DIAMOND INSURANCE	NORTHBROOK	WORKERS COMP INS	7
8	ORIOLE TRUST	4.950%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	8
9	RAJCHENBACH FAMILY TRUST	25.000%	THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING / MANAGE	9
10	ROBERT HARTMAN FAMILY TRUST	20.050%	THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	10
11	SUSAN L. STERN	4.900%	RENAISSANCE EAST	MESA, ARIZONA	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	11
12	TODD ANDREW STERN 2001 TRUST	0.900%	RENAISSANCE PARK SOUTH, LLC	CHICAGO				12
13			RENAISSANCE VILLAGE AL	MESA, ARIZONA				13
14			RENAISSANCE VILLAGE IL	MESA, ARIZONA				14
15			RENAISSANCE WEST	MESA, ARIZONA				15
16			CLAREMONT - HANOVER PARK	HANOVER PARK				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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0	See Attached	0.66	1.65%		\$		1
2	Jack Rajchenbach	Relative	Administrative	0	See Attached	5	7.69%	Alloc. Salary	9,259	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,259		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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,283,340	16	\$ 36,192	\$	72,270	\$ 2,038	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,283,340	16	143,887		72,270	8,103	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,283,340	16	226,766	211,441	72,270	12,770	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	16	395,673		72,270	22,282	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,283,340	16	16,986		72,270	957	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,283,340	16	2,408,992	(706,320)	72,270	135,660	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,283,340	16	4,332		72,270	244	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,283,340	16	10,088		72,270	568	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,283,340	16	11,273		72,270	635	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,283,340	16	763,008		72,270	42,968	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	16	130,120		72,270	7,328	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,283,340	16	38,953		72,270	2,194	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,283,340	16	121,491		72,270	6,842	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,283,340	16	6,400		72,270	360	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,283,340	16	50,154		72,270	2,824	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,364,315	\$		\$ 245,772	25

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MINOR EQUIPMENT	AVAIL. CENSUS DAYS	1,283,340	17	\$ 4,147	\$	72,270	\$ 234	1
2	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,283,340	17	121,500	121,500	72,270	6,842	2
3	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	17			72,270		3
4	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,283,340	17	500		72,270	28	4
5	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,283,340	17	235,467	235,467	72,270	13,260	5
6	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	15,872		72,270	894	6
7	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,283,340	17	3,225		72,270	182	7
8	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	4,586		72,270	258	8
9	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,283,340	17	1,222		72,270	69	9
10	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,283,340	17	14,168		72,270	798	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	17	1,896		72,270	107	11
12	32	INTEREST	AVAIL. CENSUS DAYS	1,283,340	17	2,164		72,270	122	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					\$ 404,746	\$ 356,967		\$ 22,793	25

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	54	9	\$ 100,000	\$ 100,000	5	\$ 9,259	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	54	9	5,000		5	463	2
3	21	OFFICE	AVG. HOURS WORKED	54	9	18,359	18,359	5	1,700	3
4	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	54	9	15,176		5	1,405	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					\$ 138,535	\$ 118,359		\$ 12,827	25

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance
Street Address 40 Skokie Blvd, Suite 105
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 559-1002
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			\$	\$		\$ 118,549	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					\$	\$		\$ 118,549	25

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Renaissance At Hillside # 0042176 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Shareholders Loan		X				\$					\$ 501,699	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Sun Joint Venture		X									56,425	6
7	Hillside Ltd. Partnership		X									28,213	7
8	See Supplemental Schedule											2,316	8
9	TOTAL Facility Related						\$					\$ 588,653	9
	B. Non-Facility Related*												
10	Interest Income		X									(2,136)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$					\$ (2,136)	14
15	TOTALS (line 9+line14)						\$					\$ 586,517	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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				\$	\$			\$ 2,194	8	
9	Allocated from Clinical Consulting		X								122	9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										2,316	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	682,258	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	544,598	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(137,660)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	477,958	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$	9,215	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	349,513	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	451,672	8	
		2007	459,357	9	
		2008	510,451	10	
		2009	695,013	11	
		2010	537,756	12	
2011 Accrual = \$537,756 x 0.09 = \$477,958					
**Beginning amount adjusted				15	
Allocated from NuCare \$6,842				16	

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 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 2010 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 2010.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 15-17-101-14-0000	Long Term Care Property	\$ 537,756.32	\$ 537,756.32
2. See Attached	Home Office Allocation	\$ 81,875.48	\$ 4,390.20
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 619,631.80	\$ 542,146.52

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Renaissance At Hillside</u>	COUNTY	<u>Cook</u>
---------------	--------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX#: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

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

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	Allocated from 7257 N. Lincoln			\$ 8,109	1
2	Allocated from Clinical Consulting			451	2
3	TOTALS			\$ 8,560	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	9,328
10	Various		1998		40,341		20	2,017	2,017	27,280
11	Various		1999		52,100		20	2,605	2,605	32,811
12	Various		2000		30,099		20	2,179	2,179	38,353
13	Various		2001		49,889		20	2,494	2,494	26,580
14	Various		2002		123,175		20	8,891	8,891	118,881
15	Various		2003		10,905		20	1,091	1,091	9,338
16	Various		2004		21,754		20	1,079	1,079	17,809
17	Various		2005		201,638		20	14,361	14,361	121,085
18	Various		2006		48,604		20	4,217	4,217	24,152
19	Various		2007		121,050		20	12,105	12,105	56,768
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

Facility Name & ID Number Renaissance At Hillside

0042176

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		163,115	5,398		4,645	(753)	30,104	68
69	Financial Statement Depreciation			193,106			(193,106)		69
70	TOTAL (lines 4 thru 69)		\$ 875,661	\$ 198,504		\$ 56,334	\$ (142,171)	\$ 512,487	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:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 875,661	\$ 198,504		\$ 56,334	\$ (142,171)	\$ 512,487	1
2	<u>Furnish & Install Door Closer & Panic Device</u>	2008	2,741		20	274	274	1,096	2
3	<u>Commerical Carpet</u>	2008	798		20	80	80	319	3
4	<u>Mural For Dementia Unit</u>	2008	650		20	65	65	255	4
5	<u>Plumbing Work</u>	2008	2,523		20	252	252	1,009	5
6	<u>Parking Lot Patching</u>	2008	1,332		20	133	133	500	6
7	<u>Remove & Replace Existing Asphalt Surface Of Parking Lot</u>	2008	2,100		20	210	210	770	7
8	<u>Furnish & Install Outside Video Cameras</u>	2008	2,195		20	220	220	787	8
9	<u>Custom Made Shaped Cornice Box</u>	2008	1,961		20	196	196	719	9
10	<u>Western Red Cedar Fencing With Gate</u>	2008	9,500		20	950	950	3,325	10
11	<u>Security Cameras</u>	2008	1,235		20	124	124	443	11
12	<u>Furnish & Install Fixtures</u>	2008	3,850		20	385	385	1,315	12
13	<u>Motor Assembly For Air Conditoner</u>	2008	2,351		20	196	196	784	13
14	<u>Cubicle Curtains, White Mesh With Tape On Top</u>	2008	3,604		20	721	721	2,523	14
15	<u>Air Supply Duct</u>	2008	1,300		20	130	130	412	15
16	<u>6 Custom Glass And Wood Partitions</u>	2008	7,200		20	720	720	2,340	16
17	<u>Counter Tops, Faucets, Baskets, And Hardware</u>	2008	6,121		20	408	408	1,360	17
18	<u>Light Fixtures And Larger Breaker For Floor Buffers</u>	2008	2,950		20	295	295	983	18
19	<u>New Awning System</u>	2008	1,490		20	149	149	484	19
20	<u>Resurface Door - 1St & 2Nd Floors</u>	2008	2,700		20	135	135	506	20
21	<u>Voice Data & Fax Cables - Labor & Materials</u>	2008	3,821		20	191	191	764	21
22	<u>Carpet In Front 4 Offices</u>	2009	2,510		20	359	359	1,076	22
23	<u>Wallcoverings And Repainting Door Frames And Doors</u>	2009	5,285		20	1,057	1,057	3,171	23
24	<u>Front Desk Canopy</u>	2009	2,800		20	280	280	817	24
25	<u>Exhaust System</u>	2009	2,800		20	280	280	793	25
26	<u>Patching Walls And Hanging Wallpaper</u>	2009	4,900		20	490	490	1,388	26
27	<u>Patching Walls And Hanging Wallpaper</u>	2009	4,200		20	420	420	1,155	27
28	<u>Fire Alarm Door Holders</u>	2009	2,500		20	250	250	646	28
29	<u>Patio Electrical Work</u>	2009	3,120		20	312	312	780	29
30	<u>Fabricating Elevator Side Panels</u>	2009	2,550		20	255	255	638	30
31	<u>Refinishing Roof To Eliminate Standing Water</u>	2009	4,375		20	438	438	1,021	31
32	<u>Replacing Concrete Patio Slab</u>	2009	2,850		20	285	285	641	32
33	<u>Regal Cherry Techno Flooring</u>	2009	4,370		20	291	291	655	33
34	TOTAL (lines 1 thru 33)		\$ 978,342	\$ 198,504		\$ 66,883	\$ (131,621)	\$ 545,961	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:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 978,342	\$ 198,504		\$ 66,883	\$ (131,621)	\$ 545,961	1
2	Tadiran Ip X 500 Telephone System	2009	24,425		20	2,443	2,443	6,310	2
3	Tadiran Ip X 500 Telephone System	2009	24,425		20	2,443	2,443	6,106	3
4	Wanderguard E. Standard System	2009	3,751		20	536	536	1,474	4
5	Refinish Roof	2009	6,075		20	608	608	1,367	5
6	Concrete, Brick, Foundation, And Sidewalk Work	2009	10,700		20	1,070	1,070	2,318	6
7	Paint And Wallpaper Work To Front Lobby	2009	6,537		20	1,307	1,307	2,833	7
8	3 Custom Coffeured Ceiling, Wood, And Acrylic	2009	3,500		20	350	350	729	8
9	Install Light Fixtures	2009	2,597		20	130	130	368	9
10	Change Locks & Electric Work	2009	2,730		20	137	137	387	10
11	Door Repair	2009	2,770		20	139	139	369	11
12	Electrical Work	2009	2,582		20	129	129	280	12
13	Wallcovering	2010	3,435		20	687	687	1,317	13
14	Emergency Back Up	2010	2,500		20	250	250	458	14
15	Remodeling-Dementia Unit-Wallpaper, Painting, Flooring..	2010	6,600		20	660	660	1,210	15
16	Renovation-Dementia Unit-Wallpaper, Painting, Flooring..	2010	17,640		20	882	882	1,544	16
17	Dementia Remodeling-Wood Casing	2010	3,345		20	335	335	558	17
18	New Floor-Conf Rm & Nursing Station	2010	3,289		20	658	658	1,096	18
19	Awnings	2010	7,239		20	1,448	1,448	2,413	19
20	Sprinklers	2010	4,880		20	488	488	773	20
21	Dementia Unit-Wood Casings Balance	2010	6,690		20	669	669	1,115	21
22	New Floor-Conf Rm & Nursing Station- Balance	2010	3,289		20	658	658	1,042	22
23	Renovate 10 Rooms-Custom Build Cabinets, Privacy Walls W/Slid	2010	16,500		20	1,650	1,650	2,338	23
24	Cornice Board W/ Welting	2010	4,346		20	435	435	869	24
25	Asphalt Repairs	2010	5,785		20	386	386	771	25
26	Electricakl Renovations To Patient Room	2010	11,100		20	1,110	1,110	1,480	26
27	Install Dry Horizontal Sidewall Sprinklers	2010	4,880		20	488	488	651	27
28	Wallcovering For 5 Room Renovation	2010	5,200		20	1,040	1,040	1,300	28
29	Electrical Wiring To Install Wander Guard System	2010	2,925		20	293	293	341	29
30	South Wing - Renovations-Walls Repairs, Painting...	2010	6,600		20	660	660	770	30
31	Installation Of Wallpaper In 5 Rooms	2010	6,895		20	1,379	1,379	1,609	31
32	Install Dry Horizontal Sidewall Sprinklers	2010	4,881		20	488	488	569	32
33	West Wing Renovation-Walls Repair, Painting..	2010	7,700		20	770	770	898	33
34	TOTAL (lines 1 thru 33)		\$ 1,204,155	\$ 198,504		\$ 91,605	\$ (106,899)	\$ 591,623	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:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 1,204,155	\$ 198,504		\$ 91,605	\$ (106,899)	\$ 591,623	1
2	Remove Parking Posts And Redo Blacktop	2010	3,500		20	233	233	272	2
3	Repair Kitchen Fridge	2010	2,787		20	139	139	221	3
4	A/C Repair	2010	4,305		20	215	215	305	4
5	Hand Rail Night Lights	2010	3,600		20	180	180	300	5
6	Furnish & Install Door Alarms	2010	2,600		20	130	130	217	6
7	19 Rooms-Remove Wallpapers, Replace Damaged & Warped Dry	2011	3,800		20	380	380	380	7
8	Remodel Utility Rooms 1St & 2Nd Flr, Tear Out Counter Tops &	2011	5,700		20	570	570	570	8
9	6 Custom Built Radiators To Match Color Of Existing Cabinets, L	2011	2,850		20	285	285	285	9
10	Rebuild Teledyne Copper Exchanger W/ New Copper Tubing, Ga	2011	3,468		20	173	173	173	10
11	Custom Build 4 Platforms And Posts, Custom Match Stain With	2011	2,820		20	282	282	282	11
12	47 Custom Resident Room Signs, 3 Different Sizes	2011	3,242		20	297	297	297	12
13	Camera System	2011	4,500		20	589	589	589	13
14	Wall Covering For 10 Room Renovation	2011	10,400		20	953	953	953	14
15	Construct Frame For Storage Room Wall, Run New Conduit For	2011	3,750		20	281	281	281	15
16	Rooms & Bathrooms Remodeling - Painting , Repair Window Sills	2011	10,500		20	875	875	875	16
17	Remove And Replace Wallcoverings In Ten Patient Rooms	2011	12,000		20	583	583	583	17
18	Replace And Install Kitchen Hood Fan	2011	4,825		20	965	965	965	18
19	Installation Of Vinyl Wall, Baseboard, Chair Rail	2011	2,650		20	133	133	133	19
20	Repair Panel For Card Access	2011	3,101		20	155	155	155	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)		\$ 1,294,553	\$ 198,504		\$ 99,025	\$ (99,479)	\$ 599,460	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,294,553	\$ 198,504		\$ 99,025	\$ (99,479)	\$ 599,460	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
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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)		\$ 1,294,553	\$ 198,504		\$ 99,025	\$ (99,479)	\$ 599,460	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 and Improvement Costs-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	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 and Improvement Costs-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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	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:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Avenue, LLC	2004	72,983	1,871	35	2,085	214	16,942	3
4	Allocated from Clinical Consulting	2004	4,055	104	35	116	12	941	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Nucare Services Corp.	2003	660	29	20	33	4	268	9
10	Allocated from Nucare Services Corp.	2004	52,629	582	20	670	88	5,169	10
11	Allocated from Nucare Services Corp.	2005	794	35	20	40	5	272	11
12	Allocated from Nucare Services Corp.	2006	1,077	47	20	54	7	289	12
13	Allocated from Nucare Services Corp.	2008	1,135	49	20	57	8	185	13
14	Allocated from Nucare Services Corp.	2009	18,269	2,499	20	913	(1,586)	2,384	14
15	Allocated from Nucare Services Corp.	2010	2,807	122	20	140	18	212	15
16	Allocated from Nucare Services Corp.	2011	152	7	20	7		7	16
17									17
18	Allocated from 7257 N. Lincoln Avenue, LLC	2005	6,653	50	20	429	379	2,710	18
19	Allocated from 7257 N. Lincoln Avenue, LLC	2004	1,450		20	73	73	544	19
20									20
21	Allocated from Clinical Consulting	2005	370	3	20	24	21	151	21
22	Allocated from Clinical Consulting	2004	81		20	4	4	30	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 and Improvement Costs-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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 163,115	\$ 5,398		\$ 4,645	\$ (753)	\$ 30,104	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 Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 793,627	\$ 1,805	\$ 90,797	\$ 88,992	10	\$ 617,701	71
72	Current Year Purchases	51,220	211	5,167	4,956	10	5,167	72
73	Fully Depreciated Assets	524,431		114	114	10	524,431	73
74								74
75	TOTALS	\$ 1,369,279	\$ 2,016	\$ 96,079	\$ 94,063		\$ 1,147,299	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		98 CHEVY VAN	2001	\$ 11,532	\$	\$ 673	\$ 673	5	\$ 11,532	76
77		Allocate from NuCare	2011	499	22	100	78	5	141	77
78										78
79										79
80	TOTALS			\$ 12,031	\$ 22	\$ 773	\$ 751		\$ 11,673	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,684,424	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,542	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,877	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,666)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,758,432	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:				\$ 1,558,296			3
4	Additions							4
5	Storage Rental				1,432			5
6	Allocated from NuCare				360			6
7	TOTAL				\$ 1,560,087			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: \$ 20,095
- 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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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.)

		1	2	3	4	5	6	7	8	
	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	\$		\$ 328,423	\$		\$ 328,423	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			292,567			292,567	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			178,321			178,321	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				359,594		359,594	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			6,062		20,213	60,586		86,861	13
14	TOTAL			\$ 6,062		\$ 819,524	\$ 420,180		\$ 1,245,766	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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,125	\$	1
2	Cash-Patient Deposits	47,509		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,747,067		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	319,662		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,975,785		8
9	Other(specify): See Attached Schedule	392,246		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,489,394	\$	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	1,412,745		15
16	Equipment, at Historical Cost	1,384,124		16
17	Accumulated Depreciation (book methods)	(2,064,521)		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	24,565		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 756,913	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,246,307	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,226,689	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,374		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	353,277		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,358		31
32	Accrued Real Estate Taxes(Sch.IX-B)	477,958		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	11,903,641		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 14,979,297	\$	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)	\$ 14,979,297	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,732,990)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,246,307	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,596,322)	1
2	Restatements (describe):		2
3	See Attached	(203,131)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,799,453)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(933,537)	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)	\$ (933,537)	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)	\$ (7,732,990)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 11,585,725	1
2	Discounts and Allowances for all Levels	(653,273)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,932,452	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,801,221	6
7	Oxygen	10,232	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,811,453	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	2	15
16	Rental of Facility Space	68	16
17	Sale of Drugs	798,523	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,576	19
20	Radiology and X-Ray	23,262	20
21	Other Medical Services	155,444	21
22	Laundry	799	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,040,674	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,136	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,136	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,787,315	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,752,274	31
32	Health Care	5,214,071	32
33	General Administration	3,250,478	33
	B. Capital Expense		
34	Ownership	2,689,898	34
	C. Ancillary Expense		
35	Special Cost Centers	1,435,386	35
36	Provider Participation Fee	378,745	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,720,852	40
41	Income before Income Taxes (line 30 minus line 40)**	(933,537)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (933,537)	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.

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	2,033	2,368	\$ 100,912	\$ 42.61	1
2	Assistant Director of Nursing	1,933	2,086	85,711	41.09	2
3	Registered Nurses	32,426	36,202	968,994	26.77	3
4	Licensed Practical Nurses	46,338	50,700	1,267,740	25.00	4
5	CNAs & Orderlies	110,917	121,380	1,277,452	10.52	5
6	CNA Trainees					6
7	Licensed Therapist	160	160	6,062	37.89	7
8	Rehab/Therapy Aides	3,014	9,516	166,024	17.45	8
9	Activity Director	3,799	4,203	113,841	27.09	9
10	Activity Assistants	13,165	14,204	129,675	9.13	10
11	Social Service Workers	4,701	5,317	157,652	29.65	11
12	Dietician	1,885	2,078	51,640	24.85	12
13	Food Service Supervisor					13
14	Head Cook	5,594	6,247	72,839	11.66	14
15	Cook Helpers/Assistants	18,835	21,413	220,184	10.28	15
16	Dishwashers					16
17	Maintenance Workers	2,349	2,566	52,041	20.28	17
18	Housekeepers	29,089	32,147	355,152	11.05	18
19	Laundry	989	1,106	11,583	10.47	19
20	Administrator	1,997	2,102	104,463	49.70	20
21	Assistant Administrator					21
22	Other Administrative	839	839	65,848	78.48	22
23	Office Manager	3,070	3,422	86,821	25.37	23
24	Clerical	11,310	12,356	212,191	17.17	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	1,948	2,126	43,593	20.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,407	4,795	191,270	39.89	33
34	TOTAL (lines 1 - 33)	300,798	337,333	\$ 5,741,688 *	\$ 17.02	34

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	770	\$ 21,566	01-03	35
36	Medical Director	Monthly	59,550	09-03	36
37	Medical Records Consultant	Monthly	2,187	10-03	37
38	Nurse Consultant	560	15,004	10-03	38
39	Pharmacist Consultant	Monthly	4,022	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	99	5,800	11-03	44
45	Social Service Consultant	50	2,813	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,478	\$ 110,942		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

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

** 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													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - 22,796
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
- (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. \$ 378,745
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.