FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0039834

Facility Name: Jackson Square Skilled Nrsg & Living

Address: 5130 West Jackson Boulevard (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	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	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			9,368	9,368	8
9	SNF/PED					9
10	ICF	58,741	2,596	1,621	62,958	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,741	2,596	10,989	72,326	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.68%

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)
None

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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 234 and days of care provided 8,766

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	361,244	90,557	14,130	465,931		465,931		465,931			1
2	Food Purchase		340,206		340,206	(17,827)	322,379	(122)	322,257			2
3	Housekeeping		16,053	411,634	427,687		427,687		427,687			3
4	Laundry		20,003		20,003		20,003		20,003			4
5	Heat and Other Utilities			317,239	317,239		317,239	(27,445)	289,794			5
6	Maintenance	70,429	57,712	244,641	372,782		372,782	16,469	389,251			6
7	Other (specify):*											7
8	**TOTAL General Services**	431,673	524,531	987,644	1,943,848	(17,827)	1,926,021	(11,098)	1,914,924			8
	B. Health Care and Programs											
9	Medical Director			24,400	24,400		24,400		24,400			9
10	Nursing and Medical Records	3,744,354	555,319	20,185	4,319,858		4,319,858	12,824	4,332,682			10
10a	Therapy			7,995	7,995		7,995		7,995			10a
11	Activities	85,434	12,273		97,707		97,707		97,707			11
12	Social Services	123,209		2,626	125,835		125,835		125,835			12
13	CNA Training											13
14	Program Transportation			15,613	15,613		15,613		15,613			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,952,997	567,592	70,819	4,591,408		4,591,408	12,824	4,604,232			16
	C. General Administration											
17	Administrative	195,087		802,676	997,763		997,763	(772,844)	224,919			17
18	Directors Fees											18
19	Professional Services			200,844	200,844	(470)	200,374	(12,856)	187,518			19
20	Dues, Fees, Subscriptions & Promotions			102,687	102,687		102,687	(58,597)	44,090			20
21	Clerical & General Office Expenses	228,015	40,650	203,854	472,519		472,519	32,838	505,357			21
22	Employee Benefits & Payroll Taxes			831,383	831,383	17,827	849,210		849,210			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,557	8,557		8,557	(75)	8,482			24
25	Other Admin. Staff Transportation			601	601		601	1,439	2,040			25
26	Insurance-Prop.Liab.Malpractice			481,498	481,498		481,498	17,792	499,290			26
27	Other (specify):*							44,826	44,826			27
28	**TOTAL General Administration**	423,102	40,650	2,632,100	3,095,852	17,357	3,113,209	(747,478)	2,365,730			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,807,772	1,132,773	3,690,563	9,631,108	(470)	9,630,638	(745,752)	8,884,886			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living #0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			169,514	169,514		169,514	159,474	328,988			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,841	38,841		38,841	593,533	632,374			32
33	Real Estate Taxes					470	470	345,056	345,526			33
34	Rent-Facility & Grounds			2,140,321	2,140,321		2,140,321	(2,139,989)	332			34
35	Rent-Equipment & Vehicles			29,540	29,540		29,540	4,522	34,062			35
36	Other (specify):*							61,006	61,006			36
37	TOTAL Ownership			2,378,216	2,378,216	470	2,378,686	(976,399)	1,402,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	13,783	396,460	813,953	1,224,196		1,224,196		1,224,196			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*	44,780		169,764	214,544		214,544	(214,544)				43
44	TOTAL Special Cost Centers	58,563	396,460	1,111,832	1,566,855		1,566,855	(214,544)	1,352,311			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,866,335	1,529,233	7,180,611	13,576,179		13,576,179	(1,936,695)	11,639,484			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(6,828)	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	(101,642)	30		9
10	Interest and Other Investment Income	(34,945)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	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	(1,430)	20		18
19	Entertainment	(1,432)	24		19
20	Contributions	(22,382)	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	(115,032)	21		24
25	Fund Raising, Advertising and Promotional	(27,619)	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	(369,471)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (680,903)		$	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)	(1,255,791)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,255,791)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,936,695)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Jackson Square Skilled Nrsg & Living

ID# 0039834

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans' Pharmacy	$ (1,654)	10	1
2	Patient Needs	(7,617)	10	2
3	Veterans Therapy	(3,777)	10	3
4	Patient Clothing	(4,229)	10	4
5	Bank Charges	(20,185)	21	5
6	COPE Dues	(8,409)	20	6
7	Non-Care Depreciation	(1,184)	30	7
8	Building Company Professional Fees	(10,995)	19	8
9	Building Company Bank Fees	(282)	21	9
10	Building Company Amortization	(5,965)	36	10
11	Building Company Licenses & Taxes	(4,665)	20	11
12	Additional R&M	10,805	06	12
13	Web Media	(25)	43	13
14	Annual Report	(175)	20	14
15	Settlement	(3,000)	43	15
16	Quest Management Fee	(166,739)	43	16
17	Non-Allowable Legal	(23,225)	19	17
18	Non-Allowable Travel	(6)	25	18
19	Miscellaneous Income	(21,528)	21	19
20	Records Copies	(311)	10	20
21	Jury Duty Income	(34)	10	21
22	Conference Room Rental	(825)	06	22
23	Director of Guest Services Salary	(44,780)	43	23
24	Clinic Allocation- Real Estate	(27,386)	33	24
25	Clinic Allocation- Utilities	(23,280)	05	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**	(369,471)		49

Jackson Square Skilled Nrsg & Living

ID# 0039834

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Jackson Square Skilled Nrsg & Living **#** 0039834 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(122)											(122)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(30,108)		2,663									(27,445)	5
6	Maintenance	9,980		6,489									16,469	6
7	Other (specify):*													7
8	**TOTAL General Services**	(20,250)		9,152									(11,098)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17,622)				30,446							12,824	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(17,622)				30,446							12,824	16
	C. General Administration													
17	Administrative			(724,820)	13,049	(61,073)							(772,844)	17
18	Directors Fees													18
19	Professional Services	(34,220)	10,995	10,335		34							(12,856)	19
20	Fees, Subscriptions & Promotions	(64,680)	4,665	1,384		34							(58,597)	20
21	Clerical & General Office Expenses	(157,027)	282	164,549		25,034							32,838	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,432)		1,184		173							(75)	24
25	Other Admin. Staff Transportation	(6)		1,206		239							1,439	25
26	Insurance-Prop.Liab.Malpractice		16,095	1,697									17,792	26
27	Other (specify):*			36,604	527	7,695							44,826	27
28	**TOTAL General Administration**	(257,365)	32,037	(507,862)	13,576	(27,864)							(747,478)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(295,237)	32,037	(498,710)	13,576	2,582							(745,752)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(102,826)	254,004	8,148		149							159,474	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34,945)	624,527	3,743		208							593,533	32
33	Real Estate Taxes	(27,386)	365,144	7,298									345,056	33
34	Rent-Facility & Grounds		(2,140,321)	332									(2,139,989)	34
35	Rent-Equipment & Vehicles			4,522									4,522	35
36	Other (specify):*	(5,965)	66,971										61,006	36
37	**TOTAL Ownership**	(171,122)	(829,675)	24,042		357							(976,399)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(214,544)											(214,544)	43
44	**TOTAL Special Cost Centers**	(214,544)											(214,544)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(680,903)	(797,638)	(474,668)	13,576	2,939							(1,936,695)	45

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Jackson Square Associates		Building Co.

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 2,140,321	Jackson Square Associates	100.00%	$	$ (2,140,321)	1
2	V	32	Interest	210	Jackson Square Associates	100.00%	624,737	624,527	2
3	V	19	Professional Fees		Jackson Square Associates	100.00%	10,995	10,995	3
4	V	21	Bank Fees		Jackson Square Associates	100.00%	282	282	4
5	V	30	Depreciation		Jackson Square Associates	100.00%	254,004	254,004	5
6	V	36	Amortization		Jackson Square Associates	100.00%	5,965	5,965	6
7	V	33	Real Estate Taxes		Jackson Square Associates	100.00%	365,144	365,144	7
8	V	26	Property & Liabilty Insurance		Jackson Square Associates	100.00%	16,095	16,095	8
9	V	20	Misc. Licenses & Taxes		Jackson Square Associates	100.00%	4,665	4,665	9
10	V	36	MIP Expense		Jackson Square Associates	100.00%	61,006	61,006	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,140,531			$ 1,342,893	$ * (797,638)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 2,663	$ 2,663	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	6,489	6,489	16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	16,783	16,783	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	10,335	10,335	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,384	1,384	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	164,549	164,549	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,184	1,184	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,206	1,206	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	1,697	1,697	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	36,604	36,604	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,148	8,148	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,743	3,743	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	7,298	7,298	27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	332	332	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	4,522	4,522	29
30	V								30
31	V	17	MANAGEMENT FEES	741,603				(741,603)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 741,603			$ 266,935	$ * (474,668)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	5,573	$ 5,573	15
16	V	17	ADMIN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	7,476	7,476	16
17	V								17
18	V								18
19	V								19
20	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	225	225	20
21	V	27	EMP. BEN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	302	302	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			$			$ 13,576	$ * 13,576	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	CLINICAL SALARIES	$	CLINICAL CONSULTING SERVICES, LLC	100.00%	$ 30,446	$ 30,446	15
16	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	34	34	16
17	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	34	34	17
18	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	22,242	22,242	18
19	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,792	2,792	19
20	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	173	173	20
21	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	239	239	21
22	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,624	3,624	22
23	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	4,071	4,071	23
24	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	149	149	24
25	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	208	208	25
26	V								26
27	V	17	MANAGEMENT FEES	61,073				(61,073)	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			$ 61,073			$ 64,012	$ * 2,939	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Hartman	Relative	Administrative	0.00%	See Attached	0.83	2.10%		$	17-7	1
2	Robert Hartman	Owner	Administrative	55.75%	See Attached	1.39	2.78%	Alloc Sal.	5,573	17-7	2
3	Gerry Jenich	Owner	Administrative	5.00%	See Attached	1.50	3.75%	Alloc Sal.	7,476	17-7	2
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,049		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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	5	UTILITIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 38,227	$	85,410	$ 2,663	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156		85,410	6,489	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	85,410	16,783	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362		85,410	10,335	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864		85,410	1,384	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	85,410	164,549	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998		85,410	1,184	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306		85,410	1,206	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362		85,410	1,697	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475		85,410	36,604	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967		85,410	8,148	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729		85,410	3,743	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761		85,410	7,298	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765		85,410	332	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914		85,410	4,522	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,832,004	$ 2,265,297		$ 266,935	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	80,000	1	5,573	1
2	17	ADMIN. - G. JENICH	AVG. HOURS WORKED	10	8	50,000	50,000	2	7,476	2
3										3
4										4
5										5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234		1	225	6
7	27	EMP. BEN. - G. JENICH	AVG. HOURS WORKED	10	8	2,021		2	302	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					$ 135,254	$ 130,000		$ 13,576	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 437,066	$ 437,066	85,410	30,446	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484		85,410	34	2
3	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,226,110	16	488		85,410	34	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	85,410	22,242	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077		85,410	2,792	5
6	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,226,110	16	2,480		85,410	173	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430		85,410	239	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028		85,410	3,624	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440		85,410	4,071	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132		85,410	149	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985		85,410	208	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 918,910	$ 756,366		$ 64,012	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	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 Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan		X				$	$ 12,118,867			$ 624,737	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholder Loan		X	Working Capital				1,500,000			38,841	6
7	Allocated From NuCare		X								3,743	7
8	See Supplemental Schedule										208	8
9	TOTAL Facility Related						$	$ 13,618,867			$ 667,529	9
	B. Non-Facility Related*											
10	Interest Income		X								(34,945)	10
11	Interest Income- Bldg Co.		X								(210)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (35,155)	14
15	TOTALS (line 9+line14)						$	$ 13,618,867			$ 632,374	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 61,006 Line # 36**

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From CCS		X				$	$			$ 208	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										208	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	284,607	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.)	$	296,864	2
3. Under or (over) accrual (line 2 minus line 1).	$	12,257	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	332,799	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.	$	470	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.	$	345,526	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	282,452	8
	2006	250,914	9
	2007	248,463	10
	2008	250,725	11
	2009	289,566	12

2010 Accrual= $316,952 X1.05 = $332,799

Allocated from NuCare: $7,298

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Skilled Nrsg & Living COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Term Care Property	$ 316,951.72	$ 289,565.72
2.	10-27-319-028-0000	Home Office Allocation	$ 81,288.74	$ 5,096.27
3.	10-27-319-028-0000	Home Office Allocation	$ 81,288.74	$ 282.92
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 479,529.20	$ 294,944.91

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Skilled Nrsg & Living COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

Medical Clinic- Costs are not included on Schedule V

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	89,364	1987	$ 71,619	1
2	Allocation- 2757 N. Lincoln			10,588	2
3	TOTALS	89,364		$ 82,207	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20			68,812	9
10	Various			1988	17,097		20			6,767	10
11	Various			1989	19,023		20			8,482	11
12	Various			1990	33,869		20	1,552	1,552	16,793	12
13	Various			1991	10,518		20	526	526	5,259	13
14	Various			1993	3,315		20	166	166	1,658	14
15	Various			1994	110,244		20	5,512	5,512	57,133	15
16	Various			1995	57,890		20	2,895	2,895	44,950	16
17	Various			1996	131,988		20	6,599	6,599	95,716	17
18	Various			1997	126,299		20	6,220	6,220	84,961	18
19	Various			1998	35,115		20	1,756	1,756	21,998	19
20	Various			1999	67,125		20	3,356	3,356	38,600	20
21	Various			2000	182,497		20	9,125	9,125	99,464	21
22	Various			2001	24,742		20	1,237	1,237	11,815	22
23	Various			2002	118,182		20	11,818	11,818	100,958	23
24	Various			2003	108,882		20	10,024	10,024	79,782	24
25	Various			2004	9,849		20	970	970	6,502	25
26	Various			2005	170,025		20	13,550	13,550	77,187	26
27	Various			2006	360,479		20	35,187	35,187	162,058	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		3,557,910	254,004		114,493	(139,511)	2,175,671	67
68	Related Party Allocations (Pages 12H & 12I)		201,580	6,314		8,079	1,765	34,120	68
69	Financial Statement Depreciation			127,575			(127,575)		69
70	TOTAL (lines 4 thru 69)		$ 5,545,600	$ 387,893		$ 233,065	$ (154,828)	$ 3,198,684	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 12A, Carried Forward		$ 5,545,600	$ 387,893		$ 233,065	$ (154,828)	$ 3,198,684	1
2	Generator Repair	2007	2,721		20	272	272	884	2
3	Cabinets	2008	2,900		20	290	290	773	3
4	60 Yds. Covering For Admin'S Office	2009	7,254		20	1,451	1,451	2,902	4
5	Conference Room Remodel	2009	3,800		20	380	380	697	5
6	Cables From Generator Control Panel	2009	4,976		20	498	498	995	6
7	Sprinklers	2009	5,385		20	359	359	539	7
8	Refacing Doors. Bannister, And Nurses Station	2009	15,610		20	1,561	1,561	2,211	8
9	25 Cubicle Curtains	2009	2,793		20	279	279	349	9
10	60 Boxes Armstrong	2009	3,098		20	310	310	387	10
11	1 Trane Compressor	2009	8,204		20	1,641	1,641	2,735	11
12	First Q Digital Reset; 1 Passive Infared Sensor Door; Plastic Bump	2009	5,912		20	591	591	1,035	12
13	29 Indoor Cameras; 3 Outdoor Cameras; 32 Dvrs	2009	18,730		20	1,873	1,873	2,653	13
14	Chair Rails	2009	4,508		20	902	902	1,653	14
15	Architect Fees	2009	4,330		20	619	619	722	15
16	#34672 Flooring, Walls- Bathroom	2009	33,198		20	3,320	3,320	5,810	16
17	#34954 Wall Covering/Guards	2009	2,682		20	268	268	425	17
18	#34949 1St/End Floor Wall Covering, Carpet	2009	26,686		20	2,669	2,669	4,225	18
19	Room Partitions	2010	7,000		20	700	700	700	19
20	Vinyl Tile- 4Th Flr Hallway, Parlor, Pantry	2010	6,124		20	340	340	340	20
21	High Techcontroller/Digital Components/Wiring On Boiler	2010	7,750		20	646	646	646	21
22	Vinyl Tile- 4Th Flr Hallway, Parlor, Pantry	2010	5,834		20	199	199	199	22
23	Clinic Project-Cabinetry, Counter Tops	2010	4,400		20	217	217	217	23
24	1 Vulcan Hart Boiler	2010	2,842		20	304	304	304	24
25	Water Pump	2010	6,229		20	831	831	831	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 12B, Carried Forward		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 12C, Carried Forward		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	1
2									2
3									3
4									4
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,738,566	$ 387,893		$ 253,584	$ (134,309)	$ 3,230,915	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:	1980	3,173,042	254,004	39	95,250	(158,754)	2,096,187	2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	11,647		20	582	582	6,413	9
10	Various	2005	61,061		20	3,053	3,053	21,051	10
11	Screen, Lint With Snap	2007	119		20	6	6	24	11
12	Duplex Receptacles	2007	650		20	33	33	131	12
13	Universal Wide Style Handrail	2007	3,458		20	173	173	692	13
14	Furnish Hardware - Audio And Video Cable	2007	2,500		20	125	125	500	14
15	Duro Last Roofing System	2007	17,750		20	888	888	3,551	15
16	Compressor	2007	16,445		20	822	822	3,289	16
17	Fire Alram (Repair)	2007	4,364		20	218	218	873	17
18	Smoke Detector And Alarm	2007	1,293		20	65	65	259	18
19	Waterflow Labor/Pipe Fitting Fire Alram	2007	3,940		20	197	197	788	19
20	Walkway	2007	5,500		20	275	275	1,100	20
21	Renovated Parking Lot	2007	6,800		20	340	340	1,360	21
22	Fire Alarm Control Panel	2007	9,252		20	463	463	1,851	22
23	2 Ccd Cameras	2007	1,853		20	93	93	371	23
24	Duro Lasting Roof Work	2007	17,750		20	888	888	3,551	24
25	Bristol/Modules For Chiller	2007	5,832		20	292	292	1,167	25
26	Compresor Replacer	2007	2,823		20	141	141	564	26
27	Elevator Work	2007	2,049		20	102	102	409	27
28	Doors	2007	1,425		20	71	71	285	28
29	Telephone System	2008	43,547		20	2,177	2,177	6,532	29
30	Digital Video Multiplexer Recorder, Color Dome Camera	2008	2,693		20	135	135	404	30
31	Elevator Car Doors	2008	3,875		20	194	194	582	31
32	Furnish and Install Insulated Glass Window	2008	25,820		20	1,291	1,291	3,873	32
33	Furnish and Install Solid Iron Fence	2008	4,860		20	243	243	729	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2	Upholster Cornice & Roller Shades and Re-install	2008	27,819		20	1,391	1,391	4,173	2
3	Vinyl Floor Tile and Cove Base	2008	9,800		20	490	490	1,470	3
4	Additional Labor for Tile Installation	2008	370		20	19	19	56	4
5	Vinyl Tile Adhesives and Floor Patch Materials	2008	777		20	39	39	117	5
6	Sample Roller Shade	2008	304		20	15	15	45	6
7	Tile work, Wallcoverings	2008	47,481		20	2,374	2,374	7,122	7
8	Renovation - Wallcoverings / Flooring / 1st & 2nd Floor	2008	29,588		20	1,479	1,479	4,438	8
9	Replacing Exit Faces and Lightbox Lexan Faces	2008	9,670		20	484	484	1,451	9
10	Monitoring System	2008	1,753		20	88	88	263	10
11									11
12									12
13									13
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31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 3,557,910	$ 254,004		$ 114,493	$ (139,511)	$ 2,175,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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- 7257 N. Lincoln	2004	90,278	2,315	35	2,579	264	18,378	3
4	Allocated- Clinical Consulting Services	2004	5,015	129	35	143	14	1,021	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated- 7257 N. Lincoln	2005	8,230	359	20	531	172	2,821	9
10	Allocated- 7257 N. Lincoln	2004	1,794		20	90	90	583	10
11									11
12	Allocated- Clinical Consulting Services	2005	457	20	20	30	10	157	12
13	Allocated- Clinical Consulting Services	2004	100		20	5	5	32	13
14									14
15	Allocated- NuCare Services	2003	816	30	20	41	11	291	15
16	Allocated- NuCare Services	2004	16,565	604	20	829	225	5,565	16
17	Allocated- NuCare Services	2005	982	36	20	49	13	287	17
18	Allocated- NuCare Services	2006	1,332	49	20	67	18	291	18
19	Allocated- NuCare Services	2008	1,404	51	20	70	19	158	19
20	Allocated- NuCare Services	2009	71,134	2,594	20	3,557	963	4,448	20
21	Allocated- NuCare Services	2010	3,473	127	20	88	(39)	88	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 201,580	$ 6,314		$ 8,079	$ 1,765	$ 34,120	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 937,744	$ 33,202	$ 71,872	$ 38,670	10	$ 641,068	71
72	Current Year Purchases	50,963	9,514	3,185	(6,329)	10	3,185	72
73	Fully Depreciated Assets	454,070		297	297	10	454,070	73
74								74
75	TOTALS	$ 1,442,777	$ 42,716	$ 75,354	$ 32,638		$ 1,098,324	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77		Allocated From NuCare	2010	617	22	51	29	5	51	77
78										78
79										79
80	TOTALS			$ 2,899	$ 22	$ 51	$ 29		$ 51	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,266,450	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 430,631	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 328,989	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (101,642)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,329,290	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	INSTALL NEW COMPRESS - 2000	$ 16,764	$ 838	$ 9,150	86
87	WATER FAUCETS - 2001	1,361	68	635	87
88	RESURFACE PK LOT/SIDEWALK - 20	2,778	278	2,315	88
89					89
90					90
91	TOTALS	$ 20,903	$ 1,184	$ 12,100	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.

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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:				$			3
4	Additions							4
5								5
6	Allocated From NuCare (Parking Lot)				332			6
7	TOTAL				$ 332 **			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: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 34,062 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$		$ 278,872	$		$ 278,872	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			151,316			151,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			294,829			294,829	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				306,421		306,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			13,783		88,936	90,039		192,758	13
14	TOTAL			$ 13,783		$ 813,953	$ 396,460		$ 1,224,196	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

STATE OF ILLINOIS

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,028	$ 332,101	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,760,518	2,823,465	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,925	170,149	6
7	Other Prepaid Expenses	428,048	428,048	7
8	Accounts Receivable (owners or related parties)	956,891	956,891	8
9	Other(specify): See Attached Schedule	12,489	334,488	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,273,899	$ 5,045,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		888,457	13
14	Buildings, at Historical Cost		3,333,738	14
15	Leasehold Improvements, at Historical Cost	1,666,372	6,434,368	15
16	Equipment, at Historical Cost	1,118,958	1,800,696	16
17	Accumulated Depreciation (book methods)	(2,101,926)	(6,268,949)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		171,508	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	3,829	3,829	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 687,233	$ 6,363,647	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,961,132	$ 11,408,789	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,181,791	$ 1,181,791	26
27	Officer's Accounts Payable		198,244	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,500,000	1,500,000	29
30	Accrued Salaries Payable	384,443	384,443	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,445	8,445	31
32	Accrued Real Estate Taxes(Sch.IX-B)		332,799	32
33	Accrued Interest Payable		51,937	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,092	22,092	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,141,545	2,144,709	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,238,316	$ 5,824,460	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,118,867	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)**	$	$ 12,118,867	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,238,316	$ 17,943,327	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (277,184)	$ (6,534,538)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,961,132	$ 11,408,789	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 85,503	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 85,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(362,687)	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)**	$ (362,687)	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)**	$ (277,184)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,184,523	1
2	Discounts and Allowances for all Levels	(928,271)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,256,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,793,194	6
7	Oxygen	3,427	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,796,621	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,050	16
17	Sale of Drugs	804,753	17
18	Sale of Supplies to Non-Patients	360	18
19	Laboratory	76,258	19
20	Radiology and X-Ray	26,470	20
21	Other Medical Services	171,085	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,102,976	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,945	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,945	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	22,698	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,698	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,213,492	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,943,848	31
32	Health Care	4,591,408	32
33	General Administration	3,095,852	33
	B. Capital Expense		
34	Ownership	2,378,216	34
	C. Ancillary Expense		
35	Special Cost Centers	1,438,740	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,576,179	40
41	**Income before Income Taxes (line 30 minus line 40)****	(362,687)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (362,687)	43

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

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

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

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,406	$ 115,610	$ 48.05	1
2	Assistant Director of Nursing	2,575	2,785	102,928	36.96	2
3	Registered Nurses	27,374	30,081	826,624	27.48	3
4	Licensed Practical Nurses	48,970	53,287	1,290,015	24.21	4
5	CNAs & Orderlies	111,561	122,882	1,297,595	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,346	2,346	33,057	14.09	9
10	Activity Assistants	4,744	5,200	52,377	10.07	10
11	Social Service Workers	4,762	5,408	123,209	22.78	11
12	Dietician	3,671	4,057	79,446	19.58	12
13	Food Service Supervisor					13
14	Head Cook	4,935	5,624	64,092	11.40	14
15	Cook Helpers/Assistants	19,150	21,714	217,706	10.03	15
16	Dishwashers					16
17	Maintenance Workers	4,301	4,632	70,429	15.20	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,878	2,006	87,271	43.50	20
21	Assistant Administrator					21
22	Other Administrative	2,220	2,390	107,816	45.11	22
23	Office Manager	3	3	86	28.67	23
24	Clerical	22,701	24,836	227,929	9.18	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	3,882	4,226	111,582	26.40	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,055	2,272	58,563	25.78	33
34	TOTAL (lines 1 - 33)	269,000	296,155	$ 4,866,335 *	$ 16.43	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	314	$ 14,130	01-03	35
36	Medical Director	Monthly	24,400	09-03	36
37	Medical Records Consultant	Monthly	368	10-03	37
38	Nurse Consultant	243	4,811	10-03	38
39	Pharmacist Consultant	Monthly	11,030	10-03	39
40	Physical Therapy Consultant	Monthly	7,995	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	46	2,626	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	603	$ 65,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	116	3,976	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	116	$ 3,976		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Farhat Sharif	Executive Dir.	0.00%	$ 91,249
Connie Ortega	Administrator	0.00%	72,449
Margo Marasa	Administrator	0.00%	14,823
Kathleen Brander	Dir. Reg. Mgmt	0.00%	930
Marilyn Flaherty	VP of MC Reimb	0.00%	15,636
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 195,087

B. Administrative - Other

Description	Amount
NuCare Services- Administrative Fees	$ 741,603
Clinical Consulting Services- Administrative Fees	61,073
TOTAL (agree to Schedule V, line 17, col. 3)	$ 802,676
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 120,002
CDW Government Inc	Computer Services	664
Emdeon	Computer Services	990
Giftrap Corporation	Computer Services	6,895
HDSI	Computer Services	7,349
MDI Achieve	Computer Services	3,495
PSD Solutions	Computer Services	8,572
SAS Architects	Architecture Work	9,190
Documentation Solutions	Clinical Doc. Consultant	7,590
David Stuercke	Budgeting & Cost Control	2,960
Cares	QI Review	888
See Supplemetal Schedule		32,249
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 200,844

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,019
Unemployment Compensation Insurance	49,394
FICA Taxes	348,247
Employee Health Insurance	290,154
Employee Meals	17,827
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	8,000
Pension Expense	35,618
Dental Insurance	10,564
Other Employee Benefits	30,302
401 K Matching Expense	10,085
TOTAL (agree to Schedule V, line 22, col.8)	$ 849,210

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	20,993
Health Care Worker Background Check	
(Indicate # of checks performed 425)	4,326
Patient Background Checks	
Advertising & Promotions	27,619
Licenses & Inspections	3,715
Subscriptions	1,000
Dues	11,643
See Supplemental Schedule	1,418
Less: Public Relations Expense	( )
Non-allowable advertising	(27,619)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,090

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,125
Allocated From NuCare	1,184
Allocated From CCS	173
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,482

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

Facility Name & ID Number Jackson Square Skilled Nrsg & Living # 0039834 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Ilinois Council on LTC $20,007**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,414** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **128,115**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **No**

(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? **No** 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. $ **17,827** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.